

1 hours after death.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02707

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ADAMS ARUNDEL</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Cleber Burnie</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Plaza Manor Conv. Home</i>				STREET ADDRESS (If rural give location) <i>2510 Madison Avenue</i>			
3. NAME OF DECEASED (Type or Print) (First) <i>Lula</i> (Middle) <i>Anderson</i> (Last)				4. DATE OF DEATH (Month) <i>Mar</i> (Day) <i>11</i> (Year) <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>8-25-1907</i>	9. AGE last birthday <i>50</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>NO</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mildred Ferguson - 2510 Madison Avenue</i>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>443X</i>							
IMMEDIATE CAUSE (A) <i>Congestive heart failure</i>							
ANTECEDENT CAUSE(S) DUE TO (B) <i>Hypertensive cardio-vascular disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Osteoarthritis general</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from, 19....., to, 19....., that I last saw the deceased alive on, 19....., and that death occurred at <i>11:45 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Joseph T. Taler</i>				ADDRESS (Street, city, town, state) <i>102 B & H Blvd. N.E. Cleber Burnie, Md. 312-18</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-18-58</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>MAR 18 '58</i>				<i>Charles R. Law</i>		<i>802 Madison Avenue</i>	

CERTIFICATE OF DEATH

1. USUAL RESIDENCE (COUNTY OR DISTRICT)

NAME OF DECEASED	DATE OF BIRTH	AGE	SEX	RACE	EDUCATION	RELIGION	DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

DATE OF DEATH	PLACE OF DEATH	CAUSE OF DEATH	MANNER OF DEATH

BUREAU V. S.

MAR 18 1958

RECEIVED

2001-2001

RECEIVED
MAY 10 1958
BALTIMORE
STATE DEPARTMENT OF HEALTH
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2771 CERTIFICATE OF DEATH

Reg. Dist. No.

02708

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 16ys, 9mos, 2da	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital, Md.		d. STREET ADDRESS 2714 E. Biddle	
3. NAME OF DECEASED (Type or print) First Leonard Middle Armstrong Last		4. DATE OF DEATH Month 3 Day 21 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/1909
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Hole		14. MOTHER'S MAIDEN NAME Mary Lee Morton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulo Nephritis DUE TO (c) Hypertensive Encephalopathy		INTERVAL BETWEEN ONSET AND DEATH since admission on 5/24/41	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Simple Type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 12		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from January 1955 , to March 21 1958 , that I last saw the deceased alive on March 21 1958 , and that death occurred at 5:05 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D.		ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/24/58	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/25/58	22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN	22d. LOCATION (City, town, or county) (State) BALTO. - MD.
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Collick		ADDRESS 1412 E. PRESTON	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

MAR 31 '58

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 31 1958

RECEIVED

TO HOSPITAL OR AT LINDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #11, -Film G220 - 4/22/58 -mb

CERTIFICATE OF DEATH

02709

2726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William FRANCIS Atwell</u>		4. DATE OF DEATH Month Day Year <u>3 20 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/24/70</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>87</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Shadyside Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Atwell</u>		14. MOTHER'S MAIDEN NAME <u>EFFIE PAST</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Robert F. ATwell</u>		Address <u>Shadyside Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19, 1958</u> , to <u>March 20, 1958</u> , that I last saw the deceased alive on <u>March 19, 1958</u> , and that death occurred at <u>4:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		DATE SIGNED <u>3-21-58</u>	
PHYSICIAN'S NAME (Type)		M.D. <u>Lottien, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		22d. LOCATION (City, town, or county) (State) <u>Katesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 26 1958</u>	
ADDRESS <u>Galesville Md</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2772

CERTIFICATE OF DEATH

02710

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>Saratoga</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>34 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 S. Campmeade Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Viola</u> First <u>Hannah</u> Middle <u>Bange</u> Last		4. DATE OF DEATH <u>March</u> Month <u>12</u> Day <u>1958</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>Henry Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Lara Gold Hammer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213 20 1449</u>	
17. INFORMANT <u>Catherine Nicholson</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of descending Colon</u> 153.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>10 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>3/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/12/58</u> , 19 <u>58</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball</u> M.D. <u>Linthicum</u>		ADDRESS (Street, city or town, state) <u>—</u> DATE SIGNED <u>3/12/58</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 15-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Campbell</u> ADDRESS <u>—</u>		24a. REC'D BY REGISTRAR <u>MART 17 58</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02711

1. PLACE OF DEATH a. COUNTY <i>SANNS NURSING HOME</i> <i>Anne Arundel Co.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville - Md.</i>		c. LENGTH OF STAY IN 1b <i>13 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SANNS-Nursing-Home.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth (Eliza) Beard</i>		4. DATE OF DEATH Month <i>3</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb-19-1894</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>2</i> Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Lemon Beall</i>		14. MOTHER'S MAIDEN NAME <i>Martha-Tucker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary V. SANN - Cecil Rd. Md.</i>		Address <i>Millersville</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a); (b); and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Acute Lobar Pneumonia.</i> DUE TO (b) <i>Hemiplegia right lateral</i> DUE TO (c) <i>Cerebral thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetes</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>1</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 6-58</i> , 19 <i>March 6-58</i> , that I last saw the deceased alive on <i>March 6-58</i> , and that death occurred at <i>11 A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>DR. JOSEPH LIESKEY</i> PHYSICIAN'S NAME (Type) <i>ODONTON, MARYLAND</i>		ADDRESS (Street, city or town, state) <i>Odenton Md</i> DATE SIGNED <i>3-6-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>3-8-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Haps Chapel</i>		22d. LOCATION (City, town, or county) (State) <i>Edgewater, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping</i> ADDRESS <i>ANNE ARUNDEL, Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 11 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>W. J. ...</i>			

BUREAU V. S.

MAR 11 1959

RECEIVED

2774

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> 47x-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CHILDRENS CENTER</u>		d. STREET ADDRESS <u>10 ANACOSTIA RD. SE.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CWENDOLYN</u> - <u>BELL</u>		4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>15</u> <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5 1951</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REUBEN BELL</u>		14. MOTHER'S MAIDEN NAME <u>GEORGETTA RILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>REUBEN BELL</u>		Address <u>10 ANACOSTIA RD. SE. WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>493X</u> DUE TO (c) <u>MENTAL RETARDATION</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MENTAL RETARDATION</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 11</u> , 19 <u>58</u> to <u>March 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 15</u> , 19 <u>58</u> , and that death occurred at <u>10:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Margaret W. Mola</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>CHILDRENS CENTER LAUREL, MD.</u> <u>3-15-58</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Margaret Mola</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines + Co. 901-3rd ST. S.W.</u>		24a. REC'D BY REGISTRAR <u>W. H. Smith</u>	
ADDRESS <u>Washington D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE, MD

DATE

DECEASED

PLACE OF DEATH

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

BUREAU V. S.

MAR 19 1950

RECEIVED

2727

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>G. G.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood - Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Reeves Bell</u>				4. DATE OF DEATH Month Day Year <u>3 - 11 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Counsel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>S.P.R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>NASHVILLE, TENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BELL</u>				14. MOTHER'S MAIDEN NAME <u>MARIE GATLIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>W.W.1</u>		17. INFORMANT Address <u>MABEL L. BELL HARWOOD MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/29/52</u> , 19 <u>52</u> , to <u>March 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 10</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lottman, Md.</u> DATE SIGNED <u>3-11-58</u> ACTUAL SIGNATURE <u>Emil H. Wilson</u> M.D. PHYSICIAN'S NAME (Type) <u>Emil H. Wilson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jo. Gaudin's Sons, Inc.</u> ADDRESS <u>1176 P. Ave. NW.</u>				24a. REC'D BY REGISTRAR <u>MAR 13 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 13 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2775

CERTIFICATE OF DEATH

02714

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena</u>	
c. LENGTH OF STAY IN 1b <u>35 yrs.</u>		d. STREET ADDRESS <u>7th. st., Green Haven</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7th. st., Green Haven</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>BOHUSLAV</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Skillworker, (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Derby Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u> ✓	
13. FATHER'S NAME <u>John A. Bohuslav</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>////////</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Theresa Bohuslav,</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral Vascular Collapse</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Arterial Embolism Left Leg</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Disease Sys.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1st.</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/18/58</u> , 19 <u>58</u> , to <u>3/2/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/2/58</u> , 19 <u>58</u> , and that death occurred at <u>4 40</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>113 7th Ave Brooklyn, N.Y.</u> DATE SIGNED <u>3/4/58</u>			
ACTUAL SIGNATURE <u>Leonard H. Flax</u> M.D.		DATE SIGNED <u>3/4/58</u>	
PHYSICIAN'S NAME (Type) <u>Leonard H. Flax</u>		<u>Balti w, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alb. Leach</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Page Two

BUREAU V. S.

MAR 6 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2776

CERTIFICATE OF DEATH

Reg. Dist. No.

02715

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2ys, 7mos, 3das	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 1521 McCulloh Street	
3. NAME OF DECEASED (Type or print) First Richard Middle Avon Last Brooks		4. DATE OF DEATH Month 3 Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. CITIZEN OF WHAT COUNTRY? U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Brooks		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-1297	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Aneurysm of Aorta DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Arteriosclerosis DUE TO (c) Syphilitic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Instant death Known to us since 8/21/55	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Paranoid Type		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month _____ Day _____ Year 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from August , 19 55 , to March 24 , 19 58 , that I last saw the deceased alive on March 24 , 19 58 , and that death occurred at 11:45A AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/24/58 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-29-58		22b. DATE THEREOF 3-29-58	
22c. NAME OF CEMETERY OR CREMATORY MT. CALVARY		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Jackson Funeral Home		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

TWIN BOND

5000 COMMERCE
BALTIMORE 18

BUREAU V. S.

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02716

2777

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. LENGTH OF STAY IN 1b <u>9ys, 3mo, 8ds.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Warren</u> Middle <u>Brooks</u> Last <u>Brooks</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12/25/88</u>
9. AGE (In years last birthday) yrs. <u>69</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Dennie Brooks</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Marshit</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition and Congestive Heart Failure</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis with Psychotic Reaction</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Hour <u>_____</u> o. m. <u>_____</u> p. m. <u>_____</u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>57</u> , to <u>March 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 7</u> , 19 <u>58</u> , and that death occurred at <u>2:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>3/7/58</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D. PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u> <u>Crownsville State Hospital, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>3/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Sch. of Med.</u>		22d. LOCATION (City, town, or county) (State) <u>29 S. Greene St. Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u>		ADDRESS <u>108 Wash. St. Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>3/10/58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Louch</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

APPROVED

BUREAU V. S.

MAR 12 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2778

CERTIFICATE OF DEATH

02717

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2ys, 10mos, 2da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 631 W. Lanvale	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Henry Last Brown		4. DATE OF DEATH Month 3 Day 23 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Brown		14. MOTHER'S MAIDEN NAME Mary Alice Lightfoot	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 491X DUE TO (c) -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19 -----		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from May 21, 1956 , to March 23 , 19 58 , that I last saw the deceased alive on March 23 , 19 58 , and that death occurred at 9:10A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/24/58			
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D.			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-28-58	
22c. NAME OF CEMETERY OR CREMATORY WESTERN STAR		22d. LOCATION (City, town, or county) (State) BALTIMORE MD	
23. FUNERAL DIRECTOR'S SIGNATURE William A. Jackson		ADDRESS 916 Pennsylvania	
24a. REC'D BY REGISTRAR DATE MAR 27 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2779

CERTIFICATE OF DEATH

Reg. Dist. No.

02718

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Dardsonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Putland Road, Dardsonville, Md</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Thomas</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>		9. AGE (In years last birthday) yrs. <u>54</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Sedona Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>-</u>		17. INFORMANT <u>J. Howard Beard</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I lost saw the deceased alive on _____, 19____, and that death occurred at <u>4:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>J. Howard Beard</u> M.D.							
PHYSICIAN'S NAME (Type) <u>J. Howard Beard</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3.24-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Sabor</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash St. Annapolis, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED: *James Howard*
AGE: *32* SEX: *M*
DATE OF BIRTH: *1906*
PLACE OF BIRTH: *St. Louis, Mo.*
OCCUPATION: *Electrician*
CAUSE OF DEATH: *Heart Disease*
DATE OF DEATH: *Mar 26 1938*
PLACE OF DEATH: *Home*
SIGNATURE OF PHYSICIAN: *J. Howard*
SIGNATURE OF WITNESSES: *J. Howard*
DATE: *Mar 26 1938*

BURKAY X. 3

MAR 26 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2728

CERTIFICATE OF DEATH

02719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A. A. GENERAL HOSPITAL				d. STREET ADDRESS 201 CHEESAPEAKE AVE			
3. NAME OF DECEASED (Type or print) First Middle Last MARY CARRIE BROWN				4. DATE OF DEATH Month Day Year MARCH 1 1958			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/6/1903	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GEORGE TROTT			14. MOTHER'S MAIDEN NAME HESTER BOYD				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. ROLAND A. BROWN #2	17. INFORMANT ROLAND A. BROWN #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CORONARY ARTERY DIS. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 14 HRS crkman
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from JAN 18 1955 , to 1 MAR 1958 , that I last saw the deceased alive on 1 MAR 1958 , and that death occurred at 2 P M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward H. Beck				ADDRESS (Street, city or town, state) 44 Southgate Ave			
PHYSICIAN'S NAME (Type) ANNAPOLIS, MD				DATE SIGNED 3/3/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/4/58	22c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD		
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons				ADDRESS ANNAPOLIS, MD		24a. REC'D BY REGISTRAR DATE MAR 6 '58	24b. REGISTRAR'S SIGNATURE W. B. Bouch

RECEIVED

MAR 6 1958

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

2729

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION DOA Anne Arundel General Hospital				d. STREET ADDRESS Long Point on the Severn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AVERY Middle T Last BRUNNER				4. DATE OF DEATH Month MARCH Day 6 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 9, 1897		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printing Office		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Cleveland, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emil Jacoby Brunner				14. MOTHER'S MAIDEN NAME Mary E. Bentz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 579-28-9251		17. INFORMANT Mrs. Vida Grace Brunner- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 30 Min 5 Years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 53 , to Mar 6 , 19 58 , that I last saw the deceased alive on Mar 3 , 19 58 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward G. Skerrett				ADDRESS (Street, city or town, state) Gambrills, Md		DATE SIGNED 3-8-58	
PHYSICIAN'S NAME (Type) Edward Skerrett MD				Gambrills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 11, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR MAR 11 '58	
				24b. REGISTRAR'S SIGNATURE W. Leach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESS</p>	

BUREAU V. S.

MAR 11 1933

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02721

2730

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>C. C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis 10</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL HOSP.</u>				d. STREET ADDRESS <u>52 Shaw St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THOMAS</u> First <u>E.</u> Middle <u>BRYAN</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-1903</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Helper Civil Engineer Inc.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Thomas E. Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>218-05-0311</u>		17. INFORMANT Address <u>Shatter Bryan - Anna, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Paul F. Guerin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>PAUL F. GUERIN</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr. - Anna, Md.</u>				ADDRESS		24a. RECEIVED BY REGISTRAR DATE <u>March 18 58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Reese</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

FILED
JAN 11 1959
BONMID

BUREAU V. S.

MAR 19 1959

RECEIVED

2730 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Pasadena</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		<u>Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Light & Mission Sts</u> <u>Pasadena Md</u>				STREET ADDRESS (If rural give location) <u>Light & Mission Sts</u>			
3. NAME OF DECEASED (Type or Print) <u>Eugene</u> (First) <u>Harward</u> (Middle) <u>Bussey</u> (Last)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>9</u> (Year) <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Nov 23, 1907</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper Pressman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>		11. BIRTHPLACE (State or foreign country) <u>Sudley Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert H. Bussey</u>				14. MOTHER'S MAIDEN NAME <u>Queenie Thacker Franklin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>216-07-9242</u>		17. INFORMANT & ADDRESS <u>Wife Same</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>162.1</u> IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchogenic Carcinoma (generalized)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. el work el work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1955</u> , 19 <u>55</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 March</u> , 19 <u>58</u> , and that death occurred at <u>4:15</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Robert R. Halpin</u>				ADDRESS (Street, city, town, state) <u>M.D. Severna Park Md</u>		DATE SIGNED <u>3-9-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 13/58</u>		NAME OF CEMETERY OR CREMATORY <u>London Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR DATE <u>MAR 13 '58</u>		REGISTRAR'S SIGNATURE <u>W. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>T. J. Sington</u>		ADDRESS <u>Elton Burnie, Md</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

NAME OF DECEASED

SEX AND AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

RELIGION

THE MEDICAL EXAMINER

4-10-58

BUREAU V. 3

MAR 13 1958

RECEIVED

INVESTIGATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2731

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 10			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ETHEL Middle CARMAN Last CARMAN				4. DATE OF DEATH Month 3 Day 3 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-23-1909	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore Md	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME William W. Johnson				14. MOTHER'S MAIDEN NAME Nora Goodman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —		17. INFORMANT Edgar L. Carman		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intra-abdominal hemorrhage due to Rupture of a tumor of the left Adrenal Gland Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 239X INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF 3-6-1958		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sr.				24a. REC'D BY REGISTRAR Alf Leach		24b. REGISTRAR'S SIGNATURE Alf Leach	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

BUREAU V. 2

MAR 6 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 7, 10, 11, 12, 13, 14, 15 Film G226 3-19-58 et

2781

CERTIFICATE OF DEATH

Reg. Dist. No.

02724

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital, Md.</u>		d. STREET ADDRESS <u>1351 W. North Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Carter</u> Last <u>Carter</u>		4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years lost birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>??</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u> </u>		Address <u> </u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypostatic Pneumonia; Septycemia</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>
20f. (City or town) <u> </u>		(County) <u> </u> (State) <u> </u>
21. I certify that I attended the deceased from <u>December 9, 1957</u> to <u>March 8, 1958</u> , that I last saw the deceased alive on <u>March 8, 1958</u> and that death occurred at <u>9:28 P. M.</u> from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>Hildegard H. Reissman</u> M.D.		DATE SIGNED <u>3/8/58</u>
PHYSICIAN'S NAME (Type) <u>Hildegard H. Reissman</u>		<u>Crownsville State Hospital, Md.</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u> </u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>
22d. LOCATION (City, town, or county) <u>Baltimore MD</u>		(State) <u> </u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Gray D. Wilson</u>		ADDRESS <u>2004 Orleans St.</u>
DATE <u>MAR 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

CERTIFICATE OF DEATH

REGISTERED

• This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the State Department of Health.

BUREAU V. A.

MAR 14 1958

RECEIVED

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

MAR 7 1959

RECEIVED

2783 CERTIFICATE OF DEATH

Reg. Dist. No. 02726

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Mildred</u> Last <u>Clark</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife (own home)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Blair Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Nellie M. Howard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Stanley C. Clark</u>			
				Address <u>8002 Piney Branch Road Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Vascular Disease</u> DUE TO (c) <u>Hypertension - severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>15 yrs</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>July 18, 1958</u> to <u>Mar 22, 1958</u> , that I last saw the deceased alive on <u>18 Mar 1958</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.B. Sasser</u> M.D.				ADDRESS (Street, city or town, state) <u>Wpms Marlboro Md</u> DATE SIGNED <u>12 Mar 58</u>			
PHYSICIAN'S NAME (Type) <u>R. B. Sasser</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 25, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey,</u>		ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 26 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Humphrey</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 26 1958

BUREAU X. 3

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
DATE OF REGISTRATION: [illegible]

2784

CERTIFICATE OF DEATH

Reg. Dist. No. 02727

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Pk.</u>		c. LENGTH OF STAY IN 1b <u>Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4905 Brookwood Road</u>				d. STREET ADDRESS <u>4905 Brookwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Cole</u> Last <u>Cole</u>				4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1871</u>		9. AGE (In years lost birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Dabney Baker</u>				14. MOTHER'S MAIDEN NAME <u>Lacy Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiac vascular disease</u> DUE TO (c) <u>hemiplegia</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>hemiplegia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 19 56</u> to <u>Mar 27 19 58</u> , that I last saw the deceased alive on <u>Mar 27, 19 58</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Philip W Keister</u>				ADDRESS (Street, city or town, state) <u>3021 Tatarow Ave</u>		DATE SIGNED <u>3/28/58</u>	
PHYSICIAN'S NAME (Type) <u>KEISTER</u>				<u>Balto 25 Md</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/31/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes 130 E. Fort Ave.</u>				24a. REC'D BY REGISTRAR <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

RECEIVED

BUREAU V. S.

MAR 31 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02728

2732

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth Lizzie Coleman</u>		4. DATE OF DEATH Month Day Year <u>3 11 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Head</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Franklin Hotel Annapolis, Md.</u>	
11. BIRTH PLACE (State or foreign country) <u>21 S. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Perry Dobson</u>		14. MOTHER'S MAIDEN NAME <u>Bachel Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>181-20-2742</u>	
17. INFORMANT <u>many Jones</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction (Left Internal)</u> DUE TO <u>332x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Capsule (Posterior Portion)</u> DUE TO <u>11 Days</u> (c) <u>due to Hypertension</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 4, 1958</u> to <u>March 11, 1958</u> , that I last saw the deceased alive on <u>March 11, 1958</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. L. Richardson</u>		ADDRESS (Street, city or town, state) <u>110-CLAY ST ANNAPOLIS, Md</u>	
PHYSICIAN'S NAME (Type) <u>William Seese</u>		DATE SIGNED <u>3/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Seese</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>AR 1 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Seese</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 1-5-58

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		1923		MEMPHIS, TENN		APR 4 1968		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. SERVICE		18. SOCIAL SECURITY NUMBER		19. HUSBAND'S NAME		20. WIFE'S NAME		21. CHILDREN'S NAMES		22. CHILDREN'S DATES OF BIRTH		23. CHILDREN'S PLACES OF BIRTH		24. CHILDREN'S OCCUPATIONS	
None		Single		High School		None		None		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 14 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2733

CERTIFICATE OF DEATH

02729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel GENERAL</u>		d. STREET ADDRESS <u>10 CORNHILL ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>ERIC</u> Middle <u>COLLINS</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 18 1958</u>
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton Collins</u>		14. MOTHER'S MAIDEN NAME <u>ORA Blake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>MRS. ORA COLLINS 10 CORNHILL ANNAPOLIS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SEPTICEMIA</u> <u>772.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>MALNUTRITION</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 18</u> , 19 <u>58</u> , to <u>MAR. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAR. 1</u> , 19 <u>58</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clayton Norton</u> M.D.		ADDRESS (Street, city or town, state) <u>95 CATHEDRAL ST. ANNAPOLIS</u>	
PHYSICIAN'S NAME (Type) <u>CLAYTON NORTON</u>		DATE SIGNED <u>W. H. Beach</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hallsville Cemetery Hallsville Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beech</u> ADDRESS <u>108 N. 1st St. Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>			

2063185XV5

RECEIVED

MAR 6 1958

BUREAU V. S.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH	
10. MANNER OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF MINISTER		15. SIGNATURE OF CLERGY	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF SHERIFF		20. SIGNATURE OF CLERK		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF HEALTH OFFICER		23. SIGNATURE OF VITALS		24. SIGNATURE OF DEATH	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF CREMATION		27. SIGNATURE OF OTHER	
28. SIGNATURE OF FUNERAL HOME		29. SIGNATURE OF CEMETERY		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

2785

CERTIFICATE OF DEATH

Reg. Dist. No.

02730

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D. C.</u> 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>		d. STREET ADDRESS <u>911 O St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph</u> <u>Connelly</u>		4. DATE OF DEATH Month Day Year <u>March 26</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 2, 1913</u>
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Henry Connelly</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Garity</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Files of Children's Center, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO (b) <u>cirrhosis of liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mongolism c mental retardation</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>Mar 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantravt</u> M.D.		ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantravt</u>		DATE SIGNED <u>Mar 26</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>DTS Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Jones Jr</u>		ADDRESS <u>Box 1 DTS Laurel Md</u>	
24a. REC'D BY REGISTRAR <u>Mar 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

MEDICAL CERTIFICATION

2

I

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2786 CERTIFICATE OF DEATH

02731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNVILLE STATE HOSPITAL				d. STREET ADDRESS 16, Pinkney Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle Last COOK				4. DATE OF DEATH Month March Day 8 Year 19 58			
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/I 865		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West River, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank Duvall				14. MOTHER'S MAIDEN NAME Mary Turner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Agnes Hawkins, 16, Pinkney St., Annapolis, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction assoc. with Cardiac 420.1 DUE TO Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Arteriosclerotic Cardiovascular Disease (c) Senility, Bilateral Cataracts.							INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks 15-20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility, Bilateral Cataracts.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 20 , 19 56 , to March, 8 , 19 58 that I last saw the deceased alive on March, 8 , 19 58 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital DATE SIGNED							
ACTUAL SIGNATURE Ludwig Benedikt			M.D. Crownsville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/1958		22c. NAME OF CEMETERY OR CREMATORY Brewer Hill, Annapolis, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Leese, Jr. - Anna. Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 11 1958	
				24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

TO THE REGISTER OF DEATHS
CITY OF BALTIMORE

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESSES: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

STATE OF MARYLAND
COUNTY OF BALTIMORE

IN SENATE
JANUARY 11, 1938

REPORT OF THE REGISTRAR OF DEATHS
FOR THE YEAR 1937

THE REGISTRAR OF DEATHS
FOR THE CITY OF BALTIMORE
REPORTS THAT THE DEATHS
DURING THE YEAR 1937
WAS AS FOLLOWS:

BUREAU V. S.

MAR 11 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2734

CERTIFICATE OF DEATH

Reg. Dist. No.

02732

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md.</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>87 Washington St.</i>		d. STREET ADDRESS <i>87 Washington St.</i>	
3. NAME OF DECEASED (Type or print) <i>Rachel Ann Cook</i>		4. DATE OF DEATH <i>3-19-1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-6-1864</i>
9. AGE (In years last birthday) <i>94</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Peter Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Nann Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>491X</i>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Broncho-Pneumonia</i> DUE TO (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Disease</i> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		22. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
23. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		24. (City or town) (County) (State)	
25. I certify that I attended the deceased from <i>3/16/58</i> , 19 <i>58</i> , to <i>3/19/58</i> , that I last saw the deceased alive on <i>3/19/58</i> , 19 <i>58</i> , and that death occurred at <i>2:00 P.M.</i> , from the causes and on the date stated above.		26. ADDRESS (Street, city or town, state) <i>110-CLAY ST ANNAPOLIS, MD</i>	
27. ACTUAL SIGNATURE <i>R. H. Richardson</i>		28. DATE SIGNED <i>3/21/58</i>	
29. PHYSICIAN'S NAME (Type)		30. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	
31. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		32. DATE THEREOF <i>3-23-1958</i>	
33. FUNERAL DIRECTOR'S SIGNATURE <i>William Beesett</i>		34. ADDRESS <i>108 Wash. St. Anna. Md.</i>	
35. REC'D BY REGISTRAR		36. REGISTRAR'S SIGNATURE <i>Deborah</i>	
DATE <i>MAR 26 '58</i>			

RECEIVED

MAR 27 1958

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02733

2787

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Anne Arundel

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Ferndale

c. LENGTH OF STAY IN 1b

3 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Same

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

24 Eugenia Avenue

f. STREET ADDRESS

Same

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)

Iola Marie Davis

First

Middle

Last

4. DATE
OF DEATH

Month

Day

Year

March 8th.

19 58

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

2/16/88 1889

9. AGE (In years
last birthday)
yrs.

69

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired neck ties maker

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Rudolph Norris

14. MOTHER'S MAIDEN NAME

Hannah McMann

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.
(If yes, give war or dates of service)

212-01-4974

17. INFORMANT

Mr. Mr. Richard Davis (Son)

Address 108 GLENMOUNT AVE
FERDALE MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

420.1 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a. m.
p. m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not while at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

Gustave H. Faubert, M.D.

M.D. CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

3/8/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

11 March 1958

22c. NAME OF CEMETERY OR CREMATORY

Rouzon Park

22d. LOCATION (City, town, or county)

BALTO MD

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE MAR 10 1958

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.



RECEIVED
MAR 10 1933
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2788

Item 7 #11-0227 3-28-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

02734

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WELLSBURG</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLAZA MANOR</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN G. DAWSON</u>		4. DATE OF DEATH <u>Mar 23 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walterman</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Oyster - Crabs</u>	
11c. BIRTHPLACE (State or foreign country) <u>aa Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>James E. Dawson</u>	
17. INFORMANT <u>James E. Dawson</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Arteriosclerosis general</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophy of prostate</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-15</u> , 19 <u>58</u> to <u>3-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-23</u> , 19 <u>58</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Taler</u> M.D.		ADDRESS (Street, city or town, state) <u>102 B & A Bldg. N.E.</u> DATE SIGNED <u>3-24-58</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER, M.D. Glen Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Quaker Burial Ground</u>		22d. LOCATION (City, town, or county) (State) <u>West River Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. CAUSE OF DEATH	
13. PLACE OF DEATH		14. TIME OF DEATH		15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESSES		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR	
19. PLACE OF BURIAL		20. TIME OF BURIAL		21. SIGNATURE OF BURIAL OFFICIAL		22. SIGNATURE OF MINISTER		23. SIGNATURE OF CHURCH CLERK		24. SIGNATURE OF FUNERAL HOME	
25. PLACE OF INTERMENT		26. TIME OF INTERMENT		27. SIGNATURE OF INTERMENT OFFICIAL		28. SIGNATURE OF MINISTER		29. SIGNATURE OF CHURCH CLERK		30. SIGNATURE OF FUNERAL HOME	

BUREAU V. S.

MAR 26 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2735

CERTIFICATE OF DEATH

02735

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis md</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Son's Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Payton</u> Middle <u>A</u> Last <u>Deale</u>		4. DATE OF DEATH Month <u>3</u> Day <u>17</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1881 Nov. 1</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ned Deale</u>		14. MOTHER'S MAIDEN NAME <u>Eareckson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>EMERSON DEALE</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Acute fibr. Hemorrh. Cerebral Thrombosis</u> (b) <u>Hemiplegia bilateral</u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 months</u> <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 7-58</u> to <u>March 17-58</u> , that I last saw the deceased alive on <u>March 17-58</u> , and that death occurred at <u>noon</u> on the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSEKEY</u>		DATE SIGNED <u>March 17-58</u>	
PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN</u>	22d. LOCATION (City, town, or county) (State) <u>GLEN BURNIE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lippert</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>William James</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>March 10, 1933</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Maryland</i>		HOSPITAL <i>None</i>	
OCCUPATION <i>None</i>		EDUCATION <i>None</i>		RELIGION <i>None</i>		MARRIAGE <i>None</i>		SINGLE	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		IMMEDIATE CAUSE <i>Myocardial Infarction</i>		INTERMEDIATE CAUSE <i>Coronary Artery Disease</i>		FINAL CAUSE <i>None</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF WITNESS <i>Dr. J. H. Smith</i>		SIGNATURE OF DECEASED <i>None</i>		SIGNATURE OF NEXT OF KIN <i>None</i>		SIGNATURE OF BURIAL OFFICER <i>None</i>	
DATE OF SIGNATURE <i>March 10, 1933</i>		DATE OF SIGNATURE <i>March 10, 1933</i>		DATE OF SIGNATURE <i>None</i>		DATE OF SIGNATURE <i>None</i>		DATE OF SIGNATURE <i>None</i>	

BUREAU V. S.

MAR 10 1933

RECEIVED

CERTIFICATE OF DEATH

2789

Reg. Dist. No.

Item 12 Film G227 3-31-58 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>GA Co</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>GA Co</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <i>Terndale Md</i>		LENGTH OF STAY (in this place) <i>50 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>112 Eugenia Ave</i>			
3. NAME OF DECEASED (First) (Middle) (Last) <i>Peter - De Rosa</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>March 19 1958</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>Dec 1-1889</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? U.S.A. <i>50 yrs</i>	
13. FATHER'S NAME <i>Joseph De Rosa</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>12 NOV 1918 to 1919</i>		16. SOCIAL SECURITY NO. <i>213-09-5624</i>		17. INFORMANT & ADDRESS <i>Joseph De Rosa</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>420.0 IMMEDIATE CAUSE (A) Coronary Thrombosis</i>							
ANTECEDENT CAUSE(S) DUE TO							
<i>Atherosclerotic heart disease</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<i>Asthma, Bronchial</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 1957</i> , to <i>March 19, 1958</i> , that I last saw the deceased alive on <i>March 10, 1958</i> , and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>John T. Gales</i> M.D.				ADDRESS (Street, city, town, state) <i>102 B & A Blvd. N.E. Glen Burnie, Md.</i>		DATE SIGNED <i>3-21-58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>March 21-58</i>	NAME OF CEMETERY OR CREMATORY <i>Bethel Natl Cemetery</i>		LOCATION (City, town, or county) <i>Fredrick Md Baltimore Md</i>		(State)	
24. REC'D BY REGISTRAR <i>MAR 24 '58</i>	REGISTRAR'S SIGNATURE <i>W. H. ...</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard G. Frank</i>		ADDRESS <i>Glen Burnie Md</i>		

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

Code-Death

1. Name of deceased

2. Place of death

3. Date of death

4. Time of death

5. Cause of death

6. Place of death

1. Name of deceased		2. Place of death	
3. Date of death		4. Time of death	
5. Cause of death		6. Place of death	
7. Name of physician		8. Name of medical examiner	
9. Name of funeral director		10. Name of undertaker	
11. Name of hospital		12. Name of nursing home	
13. Name of cemetery		14. Name of burial place	
15. Name of place of interment		16. Name of place of cremation	
17. Name of place of entombment		18. Name of place of inhumation	
19. Name of place of exhumation		20. Name of place of reinterment	
21. Name of place of disinterment		22. Name of place of reinterment	
23. Name of place of exhumation		24. Name of place of reinterment	
25. Name of place of disinterment		26. Name of place of reinterment	
27. Name of place of exhumation		28. Name of place of reinterment	
29. Name of place of disinterment		30. Name of place of reinterment	
31. Name of place of exhumation		32. Name of place of reinterment	
33. Name of place of disinterment		34. Name of place of reinterment	
35. Name of place of exhumation		36. Name of place of reinterment	
37. Name of place of disinterment		38. Name of place of reinterment	
39. Name of place of exhumation		40. Name of place of reinterment	
41. Name of place of disinterment		42. Name of place of reinterment	
43. Name of place of exhumation		44. Name of place of reinterment	
45. Name of place of disinterment		46. Name of place of reinterment	
47. Name of place of exhumation		48. Name of place of reinterment	
49. Name of place of disinterment		50. Name of place of reinterment	
51. Name of place of exhumation		52. Name of place of reinterment	
53. Name of place of disinterment		54. Name of place of reinterment	
55. Name of place of exhumation		56. Name of place of reinterment	
57. Name of place of disinterment		58. Name of place of reinterment	
59. Name of place of exhumation		60. Name of place of reinterment	
61. Name of place of disinterment		62. Name of place of reinterment	
63. Name of place of exhumation		64. Name of place of reinterment	
65. Name of place of disinterment		66. Name of place of reinterment	
67. Name of place of exhumation		68. Name of place of reinterment	
69. Name of place of disinterment		70. Name of place of reinterment	
71. Name of place of exhumation		72. Name of place of reinterment	
73. Name of place of disinterment		74. Name of place of reinterment	
75. Name of place of exhumation		76. Name of place of reinterment	
77. Name of place of disinterment		78. Name of place of reinterment	
79. Name of place of exhumation		80. Name of place of reinterment	
81. Name of place of disinterment		82. Name of place of reinterment	
83. Name of place of exhumation		84. Name of place of reinterment	
85. Name of place of disinterment		86. Name of place of reinterment	
87. Name of place of exhumation		88. Name of place of reinterment	
89. Name of place of disinterment		90. Name of place of reinterment	
91. Name of place of exhumation		92. Name of place of reinterment	
93. Name of place of disinterment		94. Name of place of reinterment	
95. Name of place of exhumation		96. Name of place of reinterment	
97. Name of place of disinterment		98. Name of place of reinterment	
99. Name of place of exhumation		100. Name of place of reinterment	

BUREAU V. S

MAR 22 1902

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2790

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>md.</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Millersville (Rural)</u>		LENGTH OF STAY (in this place) <u>24 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Millersville (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crain Highway</u>				STREET ADDRESS (If rural give location) <u>Crain Highway</u>			
3. NAME OF DECEASED (Type or Print) <u>Elver</u> <u>Ann</u> <u>Dicus</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5</u> <u>17</u> <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/31/1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>AA County, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Stinchcomb</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-16-1097A</u>		17. INFORMANT & ADDRESS <u>Mrs Dorothy Dicus, Same as 2</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>Coronary Thrombosis-</u>						<u>6 hrs.</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u>Carcinoma descending Colon</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. of work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>58</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles R. MacDonald</u>		M.D. <u>Islen Burnie Marshall</u>		ADDRESS (Street, city, town, state) <u>Hopping & Kirkley, Glen Burnie, md</u>		DATE SIGNED <u>3-17-58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/20/58</u>		NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		LOCATION (City, town, or county) (State) <u>Severn Crossroads, AA Co</u>	
24. REC'D BY REGISTRAR <u>MAR 20 '58</u>		REGISTRAR'S SIGNATURE <u>W. Beach</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Kirkley</u> ADDRESS <u>Hopping & Kirkley, Glen Burnie, md</u>			

1 The bottom copy may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2791

02738

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville, Maryland</u>				c. LENGTH OF STAY IN 1b <u>11 mos. 28 das</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>218 N. Montford Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>Rosie</u> Middle <u>Dix</u> Last <u>Dix</u>		4. DATE OF DEATH		Month <u>March</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/68</u>		9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Littleton Dix</u>				14. MOTHER'S MAIDEN NAME <u>Millie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X Chronic brain syndrome associated with cerebral arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>April 3, 19 57</u> to <u>March 20, 19 58</u> , that I last saw the deceased alive on <u>March 20, 19 58</u> , and that death occurred at <u>11:30 M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Hildegard Heard Dix</u>				ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u>		DATE SIGNED <u>3/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Hildegard H. Reissmann, M.D.</u> <u>Crownsville, Maryland</u>							
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville State Hosp. Med.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. W. W. W.</u>				ADDRESS <u>W. W. W. W.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. W. W. W.</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BURMAN Y. S.

MAR 26 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02739

2792

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 1yr, 7mo, 14ds	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 22 Higgins Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Downes Last Downes		4. DATE OF DEATH Month 3 Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/24/1886?
9. AGE (In years lost birthday) yrs. 70?		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Irving Downes		14. MOTHER'S MAIDEN NAME Clara	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia secondary to decubital ulcers 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Generalized Arteriosclerosis DUE TO (c) since 1956. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mental Deterioration			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. ----- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from June 22 , 19 56 , to March 5 , 19 58 , that I lost saw the deceased alive on March 5 , 19 58 , and that death occurred at 5:00a. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Reissmann		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 3/5/58			
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-1958	
22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery		22d. LOCATION (City, town, or county) (State) Easton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. B. Deshields		ADDRESS 426 Dover St. Easton Md.	
24a. REC'D BY REGISTRAR W. B. Leach		24b. REGISTRAR'S SIGNATURE W. B. Leach	
DATE MAR 10 '58			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2793 CERTIFICATE OF DEATH

Reg. Dist. No. 02740

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>163 Boone Trail</u>		d. STREET ADDRESS <u>163 Boone Trail</u>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Agnes</u> Last <u>Eberle</u>		4. DATE OF DEATH Month <u>March</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIAGE STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>58</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Newark, N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip A. Osborn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Lynah</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	
17. INFORMANT <u>Daughter, Mary E. Eberle</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver (Fatty)</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> (c) <u>Gen. Arteriosclerosis</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Since 1925</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>58</u> , to <u>1958</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8 March</u> , 19 <u>58</u> , and that death occurred at <u>1145 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u> DATE SIGNED <u>3-16-58</u>			
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u> <u>Severna Park Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner</u> ADDRESS <u>17. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Lickner</u>			

CERTIFICATE OF DEATH

JAMES B. BOND

BURKAW V. B.

MAR 18 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2791 CERTIFICATE OF DEATH

02741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. LENGTH OF STAY IN 1b 5ys, 6mo, 14ds.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton 05X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.				d. STREET ADDRESS R. F. D. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lena Middle Emory Last Emory				4. DATE OF DEATH Month 3 Day 5 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1/18/76	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 3 Days 5 Hours 1958 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cystopyelitis with hematoma DUE TO (c) Senility, Dehydration, Decubitus Ulcers						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from October , 19 57 , to March 5 , 19 58 , that I last saw the deceased alive on March 5 , 19 58 , and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/7/58							
ACTUAL SIGNATURE Lionel McHenry Mapp				M.D. Crownsville, Md.			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/10/58		22c. NAME OF CEMETERY OR CREMATORY U. of Md. Sch. of Med. (Anatomy)		22d. LOCATION (City, town, or county) (State) 29 S. Greene St. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese				ADDRESS 108 Wash. St. Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Carl W. Mudda	
24a. REC'D BY REGISTRAR 3/10/58				DATE MAR 12 '58			

BUREAU V. S.

MAR 12 1952

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02742

Reg. Dist. No.

2795

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale, P.O. Glen Burnie</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1518 Ingalls Rd. (About)</u>				d. STREET ADDRESS <u>1518 Ingalls Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Lynn Fielding</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8th.</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7/26/52</u>	
9. AGE (In years last birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert D. Fielding</u>			
14. MOTHER'S MAIDEN NAME <u>Laurel Stinckney</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>Mr. Robert D. Fielding (Father)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>812X</u> IMMEDIATE CAUSE (a) <u>Fracture of skull, Fracture of both femurs.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury, time, or place of occurrence.) <u>Ran from the front of his father's car and was hit by a car</u>			
20c. TIME OF INJURY Month, Day, Year <u>12.20 p.m. 2/8/58 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1518 Ingalls Rd.</u>	
20f. (City or town) <u>Harundale, A.A.</u>				(County) <u>Maryland.</u>		(State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				DATE SIGNED <u>2/8/58</u>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cemetery</u>		22d. LOCATION (City, town, or county) <u>Rochelle Park, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + Kirkley</u>				24a. REC'D BY REGISTRAR <u> </u>			
ADDRESS <u>Glen Burnie</u>				24b. REGISTRAR'S SIGNATURE <u> </u>			
DATE <u>MAR 11 '58</u>				 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAR 11 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 02743

2736

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>aa.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General Hospital</u>		d. STREET ADDRESS <u>113 Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>Antone</u> Middle <u>Fuehrer</u> Last <u>Fuehrer</u>		4. DATE OF DEATH Month <u>3-</u> Day <u>10-</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-3-1910</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR: Months <u>47</u> Days <u>47</u> Hours <u>47</u> Min. <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>JANITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel Janitor</u>	11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>
13. FATHER'S NAME <u>Joseph Fuehrer</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		17. INFORMANT Address <u>BUREAU OF RECORDS U.S.N</u> <u>WASHINGTON D.C.</u>	
16. SOCIAL SECURITY NO. <u>443X</u>		17. INFORMANT Address <u>BUREAU OF RECORDS U.S.N</u> <u>WASHINGTON D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE CARDIOVASCULAR DIS.</u> DUE TO <u>UNKNOWN</u> (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UNKNOWN</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/10</u> <u>1958</u> , to <u>3/10</u> <u>1958</u> , that I last saw the deceased alive on <u>3/10</u> <u>1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward J. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>44 Southgate Ave Annapolis</u> DATE SIGNED <u>3/12/58</u>	
PHYSICIAN'S NAME (Type) <u>Edward J. Beck</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Quell</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1958

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>March 26, 1958</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
10. SIGNATURE OF DECEASED <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>Mr. J. Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF DECEASED <i>John Doe</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>	
22. SIGNATURE OF DECEASED <i>John Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>	
28. SIGNATURE OF DECEASED <i>John Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>	
34. SIGNATURE OF DECEASED <i>John Doe</i>		35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>	
40. SIGNATURE OF DECEASED <i>John Doe</i>		41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>	
46. SIGNATURE OF DECEASED <i>John Doe</i>		47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>	
52. SIGNATURE OF DECEASED <i>John Doe</i>		53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>	
58. SIGNATURE OF DECEASED <i>John Doe</i>		59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>	
64. SIGNATURE OF DECEASED <i>John Doe</i>		65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>	
70. SIGNATURE OF DECEASED <i>John Doe</i>		71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>	
76. SIGNATURE OF DECEASED <i>John Doe</i>		77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>	
82. SIGNATURE OF DECEASED <i>John Doe</i>		83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>	
88. SIGNATURE OF DECEASED <i>John Doe</i>		89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>	
94. SIGNATURE OF DECEASED <i>John Doe</i>		95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>	
100. SIGNATURE OF DECEASED <i>John Doe</i>		101. SIGNATURE OF DECEASED <i>John Doe</i>		102. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. B.

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2796

CERTIFICATE OF DEATH

Reg. Dist. No. 2744

1. PLACE OF DEATH o. COUNTY <u>aa</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>aa</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <u>Joyce Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>V.</u> Last <u>Gardner</u>			4. DATE OF DEATH Month <u>3</u> - Day <u>5</u> - Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 16 - 1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>aa Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>					
13. FATHER'S NAME <u>Charles W. Brown</u>			14. MOTHER'S MAIDEN NAME <u>Alice V. Wilson</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Bla Gardner</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis - chronic</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>-</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>March 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>58</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>T. G. de Ouedo, M.D.</u>			ADDRESS (Street, city or town, state) <u>Arnold - Maryland</u>		
PHYSICIAN'S NAME (Type) <u>T. G. de Ouedo, M.D.</u>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-7-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Highways aa Co Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>			24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MAR 10 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02745

2797

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2mo, 25days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS 1526 Pulaski Street	
3. NAME OF DECEASED (Type or print) First George Middle Grandison Last Grandison		4. DATE OF DEATH Month 3 Day 4 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 73?		IF UNDER 1 YEAR Months 3 Days 4 Hours 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 218-07-3701	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia, Decubitus Ulcers 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from December 7, 1957 , to March 4, 1958 , that I last saw the deceased alive on March 4, 1958 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/6/58			
ACTUAL SIGNATURE Hildegard Heard Reissmann		PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-8-58	
22c. NAME OF CEMETERY OR CREMATORY W. Auburn Cemetery		22d. LOCATION (City, town, or county) (State) Balti Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Clifton Wainwright Edmondson		ADDRESS 2700	
24a. REC'D BY REGISTRAR -----		24b. REGISTRAR'S SIGNATURE -----	
DATE MAR 7 '58			

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

MAR 7 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G227 4-2-58 et

2798

CERTIFICATE OF DEATH

Reg. Dist. No.

02746

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 22	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale		c. LENGTH OF STAY IN 1b 7 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 307 Ferndale Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George A. Grouling		4. DATE OF DEATH Month March Day 24 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1885
9. AGE (In years by birthday) 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouse Foreman		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Grouling		14. MOTHER'S MAIDEN NAME Margaret ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-03-1496	
17. INFORMANT Mrs Ella Grouling		Address 307 Ferndale Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.S.C.V.H.R.D. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH Oct 57 - 27 March 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct , 19 57 , to March , 19 58 , that I last saw the deceased alive on 17 March , 19 58 , and that death occurred at 7:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. R. Sosnowski		M.D. 4016 Ritchie Hwy	
PHYSICIAN'S NAME (Type) A. R. Sosnowski		Balto-25-Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28, 1958	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross		22d. LOCATION (City, town, or county) (State) Brooklyn, Anne Arundel County	
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		ADDRESS 403 S. Wolfe Street	
24a. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	

BROADWAY

MAR 26 1958

RECEIVED

2799

CERTIFICATE OF DEATH

02747

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY A. A. Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md. b. COUNTY A. A. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn (Arundel Village)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn (Arundel Village)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5336 - 4th St.				d. STREET ADDRESS 5336 - 4th St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARVEY Middle FLETCHER Last GUY				4. DATE OF DEATH Month March Day 20 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1889		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Communications		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis F. Guy				14. MOTHER'S MAIDEN NAME Mary S. Powell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Helen I. Guy - 5336 - 4th St., Brooklyn			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 340.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gracchwiditis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 week 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25 , 19 53 , to 3/14 , 19 58 , that I last saw the deceased alive on 2/14 , 19 58 , and that death occurred at 4 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4700 Pennington Ave. DATE SIGNED March 21 '58							
ACTUAL SIGNATURE Sidney R. Gehlert M.D. 4700 Pennington Ave.				PHYSICIAN'S NAME (Type) Sidney R. Gehlert, M.D. 4700 Pennington Ave. Balto. 26, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Shirley Dickson & Sons - Balto				24a. REC'D BY REGISTRAR DATE MAR 21 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. 51

MAR 24 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04132

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL ANNAPOLIS		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ARUNDEL ON THE BAY RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KENNETH Middle L Last HAAS		4. DATE OF DEATH Month MARCH Day 31 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1941
9. AGE (In years last birthday) 16 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
11. BIRTHPLACE (State or foreign country) Belmont, Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles B. Haas		14. MOTHER'S MAIDEN NAME Alice C. Masters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-38-8677	
17. INFORMANT Charles B. Haas- Father- same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Suicide DUE TO 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suicide - 30-30 Winchester used	
20c. TIME OF INJURY Hour 9:30 p. m. Month, Day, Year March 31 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) nr Annapolis Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Elmer G. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Elmer G. Linhardt		DATE SIGNED March 31, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial		22b. DATE THEREOF April 2, 58	
22c. NAME OF CEMETERY OR CREMATORY Chestnut Level Cemetery		22d. LOCATION (City, town, or county) (State) Belmont, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE Al. L. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner details. The text is mirrored and difficult to read.

RECEIVED
APR 7 1958
BUREAU V. R.

Removal - [illegible]
[illegible]
[illegible]

03066

2800 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	3. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Queen Anne's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.	c. LENGTH OF STAY IN 1b 5ys, 7mos, 22das	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.	d. STREET ADDRESS R. F. D.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Annie	First Annie	Middle Mae
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 80?	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming	11b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Tom Johnson	14. MOTHER'S MAIDEN NAME Eliza Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome associated with Senile 355x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain Disease DUE TO (c) -----	INTERVAL BETWEEN ONSET AND DEATH -----	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Senile Brain Disease	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -----	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) -----	20g. (County) -----	20h. (State) -----
21. I certify that I attended the deceased from June 1955 , to March 28 1958 , that I last saw the deceased alive on March 28 1958 , and that death occurred at 7:25 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) Hildegard Heard Reissmann, M.D. Crownsville, Md.	DATE SIGNED 3/30/58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/2/58	22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital Crownsville Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. ...	24a. REC'D BY REGISTRAR APR 1 1958	24b. REGISTRAR'S SIGNATURE W. H. ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

RECEIVED

APR 7 1953

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

RECEIVED
MAY 10 1953
U.S. DEPT. OF HEALTH

FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Same</u> h. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Millersville</u>		c. LENGTH OF STAY IN 1b <u>5 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Elm Rd. Elvaton</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William James Hardy</u>				4. DATE OF DEATH First <u>March</u> Month <u>28th.</u> Day <u>1958</u> Year			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/18/00</u>		9. AGE (In years last birthday) <u>57 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Joseph Hardy</u>				14. MOTHER'S MAIDEN NAME <u>Julia Ryan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Catherine Maffa, 741 Overbrook Rd. Balt.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Charred above recognition</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>7.55</u> a. m. <u>3/28/58</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Elvaton, P.O. Millersville, A.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>3/29/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>March 31-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn A.A. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blanca A. Frank</u>				ADDRESS <u>Elvaton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Leach</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to be presented within 72 hours after death.

RECEIVED
JAN 2 1939
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
JAN 2 1939
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02749

2893

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2ys, 1mo, 11da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		18X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		d. STREET ADDRESS P. O.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Hayden Last Hayden		4. DATE OF DEATH Month 3 Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/20/1893
9. AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Laundry	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clem Hayden		14. MOTHER'S MAIDEN NAME Sarah	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. I		16. SOCIAL SECURITY NO. 217-09-7588	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial Infarction DUE TO (c) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Chronic Brain Syndrome due to Arteriosclerotic Hypertensive C. V. D.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 7, 1956 to March 18, 1958 , that I last saw the deceased alive on March 18, 1958 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Hildegard Heard Reissmann		ADDRESS (Street, city or town, state) Crownsville, Md.	
DATE SIGNED 3/18/58			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/22/58	
22c. NAME OF CEMETERY OR CREMATORY St. John's		22d. LOCATION (City, town, or county) (State) Hollywood Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtwn Md	
24a. REC'D BY REGISTRAR 3/21/58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

2

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAR 21 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02750

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 393 Deep Creek				d. STREET ADDRESS Box 393 Deep Creek		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle A. Last HEATER				4. DATE OF DEATH Month March Day 17 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal		11. BIRTHPLACE (State or foreign country) Terre Haute, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-09-0653A		17. INFORMANT Address Carl E. Frantz Sr. 1518 McHenry St 23 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia 490X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Cirrhosis of the Liver DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE William V. Lovitt, Jr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.				DATE SIGNED 3/18/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26/Mar/ 1958		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) Fredirick Road Balto. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. Bachauekas				24a. REC'D BY REGISTRAR DATE MAR 27 '58		24b. REGISTRAR'S SIGNATURE C.W. Bachauekas	

BUREAU V. 3

MAR 27 1958

RECEIVED

TO DEPUTY EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 26</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hawkins Point</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401.4</u> d. STREET ADDRESS <u>621 E. 35th. Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Heinecke</u>		4. DATE OF DEATH Month Day Year <u>March 10th. 1958 19</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/04</u>
9. AGE (In years less birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscaper</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles Heinecke</u>	
14. MOTHER'S MAIDEN NAME <u>Amelia Wineber (Lineweber)</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>220-09-2963</u>	
16. SOCIAL SECURITY NO. <u>220-09-2963</u>		17. INFORMANT Address <u>Mrs. Alice Heinecke (wife)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed Skull</u> <u>910.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>910.8</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>was pushed by a tree against the track of a crane.</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9.30 A.M. 3/10/58 19</u>	
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Improving ground, Baltimore 26 A.A. Md.</u>	
20f. (City or town) <u>Baltimore 26</u>		20g. (County) <u>A.A.</u>	
20h. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 13/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Newington</u>		ADDRESS <u>2024 Orleans St. 37</u>	
24a. REC'D BY REGISTRAR <u>Alb. Smith</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Smith</u>	

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____
2. Sex: _____
3. Age: _____
4. Date of Birth: _____
5. Place of Birth: _____
6. Usual Residence: _____
7. Cause of Death: _____
8. Manner of Death: _____
9. Signature of Medical Examiner: _____
10. Date: _____

BUREAU V. 3

MAR 12 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										02752	
Item 7, Film G227, 4/7/58 Items 8 & 9, Film G227, 4/15/58											
CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 2737 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park, Maryland d. STREET ADDRESS 216 Arundel Beach e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EDNA			First EDNA			Middle F			Last HENDERSHOT		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-1883 April 17, 1884		9. AGE (In years last birthday) 73 3/4 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) NEENAH, VA.			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Cooksey					14. MOTHER'S MAIDEN NAME Lillian Hunt						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Harriet L. Brown Address Severna Park, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic insufficiency 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstruction of bile duct DUE TO (c) Carcinoma of Ampulla of Vater										INTERVAL BETWEEN ONSET AND DEATH 1 week 3 months ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3-5-58 , 19 58 , to 3-25-58 , 19 58 , that I last saw the deceased alive on 3-24-58 , 19 58 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. DATE SIGNED APR 28 1958											
ACTUAL SIGNATURE Jesse L. Wilkins					M.D. JESSE L. WILKINS, M.D.						
PHYSICIAN'S NAME (Type) JESSE L. WILKINS, M.D.					98 Cathedral St., Annapolis, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF Mar. 28-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill			22d. LOCATION (City, town, or county) (State) Severna Park, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Jesse L. Wilkins						ADDRESS Severna Park, Md.		24a. REC'D BY REGISTRAR APR 28 1958		24b. REGISTRAR'S SIGNATURE APR 28 1958	

CERTIFICATE OF DEATH

Reg. Off. No.

1. NAME OF DECEASED [Name]		2. SEX [Male/Female]	
3. AGE [Age]		4. DATE OF BIRTH [Date]	
5. PLACE OF BIRTH [Place]		6. OCCUPATION [Occupation]	
7. MARITAL STATUS [Single/Married]		8. RELIGION [Religion]	
9. CAUSE OF DEATH [Cause]		10. DATE OF DEATH [Date]	
11. PLACE OF DEATH [Place]		12. SIGNATURE OF REGISTRAR [Signature]	
13. SIGNATURE OF DECEASED [Signature]		14. SIGNATURE OF WITNESS [Signature]	
15. SIGNATURE OF MEDICAL OFFICER [Signature]		16. SIGNATURE OF CHURCH OFFICER [Signature]	
17. SIGNATURE OF POLICE OFFICER [Signature]		18. SIGNATURE OF JUDGE [Signature]	
19. SIGNATURE OF MAYOR [Signature]		20. SIGNATURE OF GOVERNOR [Signature]	

RECEIVED
MAR 28 1958
BUREAU V. 4

2806

CERTIFICATE OF DEATH

Reg. Dist. No.

02753

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. c. LENGTH OF STAY IN 1b 4ys, 4mos, 7das d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1208 Myrtle Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Henry Last Unknown		4. DATE OF DEATH Month 3 Day 18 Year 1958	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 84 7/8 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-04-7461	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with Senile Brain Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from January , 19 53 , to March 18 , 19 58 , that I last saw the deceased alive on March 18 , 19 58 , and that death occurred at 5:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/19/58			
ACTUAL SIGNATURE [Signature]		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) L. Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3/24/58	St. Luke's Cem.	Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles Harper		24a. REC'D BY REGISTRAR MAR 27 '58	
ADDRESS 512 Pennsylvania		24b. REGISTRAR'S SIGNATURE [Signature]	
Balto. Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1933

RECEIVED

Handwritten signature

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

02754

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G Meade c. LENGTH OF STAY IN 1b Fort George G Meade d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Laurel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1411 Shore Road Rt. 5 Box 131 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last INFANT MALE HENSLEY		4. DATE OF DEATH Month Day Year March 13 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 March 1958
9. AGE (In years last birthday) yrs. 1		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harold Hensley		14. MOTHER'S MAIDEN NAME Leona Hensley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT (Father) Harold Hensley, 1411 Shore Road., Baltimore 20, Maryland		Address Baltimore	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) - DUE TO (c) - INTERVAL BETWEEN ONSET AND DEATH Lifetime			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -		20f. (City or town) (County) (State) -	
21. I certify that I attended the deceased from 12 Mar 19 58 , to 13 Mar 19 58 , that I last saw the deceased alive on 13 Mar 19 58 , and that death occurred on 0620 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md DATE SIGNED 13 Mar 1958 ACTUAL SIGNATURE Frank L. Gruskay M.D. U. S. ARMY HOSPITAL, FT G G MEADE, MD PHYSICIAN'S NAME (Type) FRANK L. GRUSKAY, CAPT, MC U. S. ARMY HOSPITAL, FT G G MEADE, MD			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 3-17-58	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B Waberton		24a. REC'D BY REGISTRAR DATE 13 Mar 58	
ADDRESS 6306 - Belair Rd, Baltimore - 6, Md		24b. REGISTRAR'S SIGNATURE CLAUDE D. LAUSIER, CWO	

CERTIFICATE OF DEATH

27

Form with multiple fields for death certificate information, including name, date, and location. The text is mirrored and difficult to read.

BUREAU V. S.

MAR 18 1933

RECEIVED

2898

CERTIFICATE OF DEATH

Reg. Dist. No.

02755

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md.</u>				c. LENGTH OF STAY IN 1b <u>8 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>US ARMY HOSPITAL, Ft Geo G. Meade, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vera</u> Middle <u>L</u> Last <u>Hickman</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 March 1906</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u>52</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Jessie Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Waller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Medical Records, Ft Geo G. Meade, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Purulent Bronchopneumonia</u> <u>053.1</u> DUE TO Septicemia, arising from staphylococcal infection of face Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>infection of face</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>22 March</u> , 19 <u>58</u> to <u>30 March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 March</u> , 19 <u>58</u> , and that death occurred at <u>2:40</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Capt. Arnold D. Fiascone</u> M.D. <u>USAH - Ft. G. G. Meade</u>				ADDRESS (Street, city or town, state) <u>Ft. G. G. Meade</u> DATE SIGNED <u>30 March 58</u>			
PHYSICIAN'S NAME (Type) <u>ARNOLD D FIASCONE, Capt, MC U.S. Army Hospital, Ft. Meade, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/3/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley, Jr.</u>				ADDRESS <u>Dundalk, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>31 Mar 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Claude D. Lausier</u>				24c. REGISTRAR'S SIGNATURE <u>Claude D. Lausier</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

APR 2 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2738

CERTIFICATE OF DEATH

Reg. Dist. No.

02756

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 77 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH ANNAPOLIS, MD.				d. STREET ADDRESS 86 Duke of Gloucester St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last HILL				4. DATE OF DEATH Month MARCH Day 4 Year 19 58			
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 March 1880		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert E. SOMMERS				14. MOTHER'S MAIDEN NAME Arvilla WELLS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NA		16. SOCIAL SECURITY NO. NA		17. INFORMANT USNH ANNAPOLIS, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heartfailure 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 March , 19 58 , to 4 March , 19 58 , that I last saw the deceased alive on 4 March , 19 58 , and that death occurred at 8:15A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) USNH ANNAPOLIS MD. DATE SIGNED 3-4-58							
ACTUAL SIGNATURE M. J. MILLER				M.D. USNH ANNAPOLIS MD.			
PHYSICIAN'S NAME (Type) M. J. MILLER LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-58		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE MAR 6 '58	
						24b. REGISTRAR'S SIGNATURE Alfred	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2739

CERTIFICATE OF DEATH

Reg. Dist. No.

02757

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>F.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HEAROLD HARBOR</u>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>HISSEY</u> Last <u>HISSEY</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>about 64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOAT YARD</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alonso Smith</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar Pneumonia, rt. mid-lobe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch. Emphysema; Ch. Bronchectasis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>58</u> , to <u>3/19</u> , 19 <u>58</u> , that I lost s/he the deceased alive on <u>3/19/58</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Krawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate in Annapolis Md.</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KRAWANS</u>		DATE SIGNED <u>3/22/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3-24-1958</u>	<u>CEDAR BLUFF</u>	<u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Giger</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. AGE <i>65</i>		4. DATE OF BIRTH <i>1914</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>LABORER</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>	
9. PLACE OF DEATH <i>HOME</i>		10. DATE OF DEATH <i>MAR 26 1959</i>	
11. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		12. SIGNATURE OF REGISTRAR <i>[Signature]</i>	
13. SIGNATURE OF WITNESS <i>[Signature]</i>		14. SIGNATURE OF DECEASED <i>[Signature]</i>	
15. SIGNATURE OF FUNERAL HOME <i>[Signature]</i>		16. SIGNATURE OF BURIAL PLACE <i>[Signature]</i>	
17. SIGNATURE OF CEMETERY <i>[Signature]</i>		18. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
19. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		20. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
21. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		22. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
23. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		24. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
25. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		26. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
27. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		28. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
29. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		30. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
31. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		32. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
33. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		34. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
35. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		36. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
37. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		38. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
39. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		40. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
41. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		42. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
43. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		44. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
45. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		46. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
47. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		48. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
49. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		50. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
51. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		52. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
53. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		54. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
55. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		56. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
57. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		58. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
59. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		60. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
61. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		62. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
63. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		64. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
65. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		66. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
67. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		68. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
69. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		70. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
71. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		72. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
73. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		74. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
75. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		76. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
77. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		78. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
79. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		80. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
81. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		82. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
83. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		84. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
85. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		86. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
87. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		88. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
89. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		90. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
91. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		92. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
93. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		94. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
95. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		96. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
97. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		98. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	
99. SIGNATURE OF INTERVIEWER <i>[Signature]</i>		100. SIGNATURE OF INTERVIEWER <i>[Signature]</i>	

BUREAU V. B.

MAR 26 1959

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1215 Wilson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AUGUSTA</u> <u>HOFFMAN</u>		4. DATE OF DEATH Month Day Year <u>March</u> <u>7</u> <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Dahle</u>		14. MOTHER'S MAIDEN NAME <u>Amelia (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. George Kaline</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs.</u> <u>7 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>55</u> , to <u>Present</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 27</u> , 19 <u>58</u> , and that death occurred at <u>4:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>H.F. Manuzak</u> M.D.			
PHYSICIAN'S NAME (Type) <u>H.F. Manuzak</u> M.D. <u>901 Edgerly Road, Glen Burnie Md. 3/7/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>March 10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Obit</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

216-1-1-10

DECEASED

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

TIME OF BIRTH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

BUREAU V. S.

MAR 10 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02759

2740

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				d. STREET ADDRESS PINES ON THE SEVERN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle A Last HOFFMAN		4. DATE OF DEATH Month MARCH Day 26 Year 19 58					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1876	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Helfrich			14. MOTHER'S MAIDEN NAME Elizabeth Otter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Lawrence Rembold- Daughter- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension - arteriosclerotic type DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death 2 wks.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 , to 3-26-1958 , that I last saw the deceased alive on 3-25-1958 , and that death occurred at 7:05 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 College Ave Annapolis, Md. DATE SIGNED 3-28-59							
ACTUAL SIGNATURE Frank M Shipley		M.D.					
PHYSICIAN'S NAME (Type) Frank Shipley MD		63 College Ave Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-58		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REGD. BY REGISTRAR DATE 3-28-59	
				24b. REGISTRAR'S SIGNATURE W. S. ...			

APR 1 1952

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral par. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.



00

I

02

2

MEDICAL CERTIFICATION

BALTIMORE, 18													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
Reg. Dist. No. 02760													
1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>A.A. County</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberstone</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberstone</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS <u>1</u>							
3. NAME OF DECEASED (Type or print) <u>Washington</u> First <u>Hutton</u> Middle <u>Hutton</u> Last						4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-18-1925</u>		9. AGE (In years last birthday) <u>32</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Well Digger</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>				11. BIRTHPLACE (State or foreign country) <u>Hope Chapel</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Harry Hutton</u>						14. MOTHER'S MAIDEN NAME <u>Florence Brown</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes W.W. No. 2</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Henry Hutton Apt. B. 1 parole</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> <u>823x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple lacerations + contusions</u> DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in automobile which struck a tree</u>									
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberstone</u>		20f. (City or town) <u>A.A.Co.</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <u>Emil H. Wilson</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>3-18-58</u>				
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		22d. LOCATION (City, town, or county) <u>Edgewater Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #108 Wash. St. China. Md.</u>						24a. REC'D BY REGISTRAR <u>MAR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE
 TIME OF DEATH



RECEIVED
 MAR 24 1933

BUREAU V. 31

MAR 24 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G226 3-24-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

2741

02761

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Davidsonville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE HARRIETTE CARR IGLEHART				4. DATE OF DEATH Month Day Year March 14 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1870	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Henry Carr				14. MOTHER'S MAIDEN NAME Caroline Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT N.E. Berry Iglehart Address Davidsonville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 TRANSITION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTATIC CARCINOMA OF LIVER DUE TO (c) 6 MONTHS INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/11 , 19 58 , to 3/14 , 19 58 , that I last saw the deceased alive on 3/13 , 19 58 , and that death occurred at 5P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Edward S. Beck M.D. PHYSICIAN'S NAME (Type) Edward S. Beck, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 17, 1958		22c. NAME OF CEMETERY OR CREMATORY All Hallows Cemetery		22d. LOCATION (City, town, or county) (State) Davidsonville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE W. J. Beach	

CERTIFICATE OF DEATH

RECEIVED
MAR 18 1939
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2742

CERTIFICATE OF DEATH

02762

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5 Drew Street - Parole</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Gilbert</u> Last <u>Isaacs</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 14-1901</u>
9. AGE (In years last birthday) yrs. <u>56</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storage Clerk-U.S.Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (State or foreign country) <u>Parole-A.A.Co.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Stophe n Isaacs</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Henderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>W.W.1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Stephen Isaacs</u>		Address <u>1811 Robert Small Rd. Forest Vil</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-27-58</u> , 19 <u> </u> , to <u>3-2-58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>2-26-58</u> , 19 <u> </u> , and that death occurred at <u>11:15</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A.T. Allen</u>		DATE SIGNED <u>3-3-58</u>	
PHYSICIAN'S NAME (Type) <u>A.T. Allen</u>		ADDRESS (Street, city or town, state) <u>Cathedral Street Annapolis, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hick</u>		ADDRESS <u>111 Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 02763											
1. PLACE OF DEATH a. COUNTY <u>A.A. CO.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. gen. Hospital</u>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>Curtis</u> Middle <u>Jackson</u> Last <u>Jackson</u>						4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1958</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 29 1928</u>		9. AGE (In years last birthday) <u>3 mos.</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Hall</u>						14. MOTHER'S MAIDEN NAME <u>Gloria Jackson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Gloria Jackson</u>		Address <u>Severna Park</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asphyxia</u> 921.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>After feeding aspiration of vomitus</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>3/19/58</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Annapolis</u>		(County) <u>AA</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. L. Linhardt</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>bur.</u>						22b. DATE THEREOF <u>28 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carpenter's Hill</u>		22d. LOCATION (City, town, or county) <u>Donis Station</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.B. Johnson</u>						ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>DeWitt</u>	

BUREAU

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2811

Reg. Dist. No. **02764**

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>1 year</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>609 Ashington Rd. Harundale</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Walter Jerome</u> Middle <u>Jackson</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>the 18th.</u> Year <u>19 58</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>5/19/85</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>			
IF UNDER 24 HRS. Hours <u></u> Min. <u></u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired employee from Proctor & Gamble</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Jackson</u>			
14. MOTHER'S MAIDEN NAME <u>FANNIE Thompson Johnson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Mrs. Flora E. Cooper, (daughter)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>3/19/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>March 22 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>			
22d. LOCATION (City, town, or county) (State) <u>13A/To. 25, Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & KIRKLEY</u>					
ADDRESS <u>Allen Burnie, Md</u>		24a. REC'D BY REGISTRAR <u>MAR 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Art. Leuch</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 24 1958

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G227 3-28-58 et

CERTIFICATE OF DEATH

2744

Reg. Dist. No.

02765

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b ANNAPOLIS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH HOFFMAN JACOBS			4. DATE OF DEATH Month Day Year MARCH 13 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 21, 1876/1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Retired Agent		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Latria, Russia			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles Jacobs				
14. MOTHER'S MAIDEN NAME Fannie Hoffman			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No no none				
16. SOCIAL SECURITY NO. none			17. INFORMANT Jack H. Jacobs 738 Longfellow Rd N.W. Washington, D.C.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho-Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 400.0 (b) 400.0 DUE TO (c) 400.0				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Charlottesville, Virginia; Central Fracture - Dislocation L. hip				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Shipped on icy steps		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shipped on icy steps		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 2:30 2/11/1958			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Annapolis, Anne Arundel, Md.			
21. I certify that I attended the deceased from Feb 11 , 19 58 , to Mar 13 , 19 58 , that I last saw the deceased alive on March 13 , 19 58 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Maurice F. Klawans			DATE SIGNED 3/14/58				
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS			ANNAPOLIS, MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 3-14-58		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln			
22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME					
24a. REC'D BY REGISTRAR DATE MAR 17 1958		24b. REGISTRAR'S SIGNATURE Q. A. ...					

MAR 17 1958

RECEIVED

2745

CERTIFICATE OF DEATH

Reg. Dist. 42766

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>76 Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md.</u>				d. STREET ADDRESS <u>22 Cornhill St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Frederick JOHNS</u>				4. DATE OF DEATH Month Day Year <u>MAR 29 19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 8, 1881</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. NAVY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. NAVY</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas JOHNS</u>				14. MOTHER'S MAIDEN NAME <u>Lucy DARNILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>WWI 248-12-9148</u>		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-29</u> , 19 <u>58</u> , to <u>3-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-29</u> , 19 <u>58</u> , and that death occurred at <u>3:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Freeman, Jr., C., MC, USN</u>				ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Anna. Md.</u>			
DATE SIGNED <u>3-30-58</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-2-1958</u>		<u>Balto. National</u>		<u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett #108 Wash. St. Arma, Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deed Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2746

CERTIFICATE OF DEATH

Reg. Dist. No. 02767

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <u>124 S. Villa Ave</u>		d. STREET ADDRESS <u>124 South Villa Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>A</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-25-1886</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	11. IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Lloyd B. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Marjett A. Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-2411A</u>	
17. INFORMANT <u>Mary Peterson - Anna, Md</u>		Address <u>Anna, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>about 1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-11-58</u> , 19 <u>58</u> , to <u>3-6-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-1-58</u> , 19 <u>58</u> , and that death occurred at <u>7:15</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Lochindorb St Annapolis, Md</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		DATE SIGNED <u>3-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-10-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ashbury</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Hesse, Jr. - Anna, Md</u>		ADDRESS <u>Anna, Md</u>	
24a. REC'D BY REGISTRAR <u>Mar 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hesse, Jr.</u>	

MAR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND-STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
2812 CERTIFICATE OF DEATH

Reg. Dist. No. 02768

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green BURNIE</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLAZA MANOR CONV. HOME</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>George A. JONES</u>		4. DATE OF DEATH <u>March 23 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1872</u>
9. AGE (In years and birthday) <u>86</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Jones.</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Riley.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>Howard Ware, Parkton, Md. P.D.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis general</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>450.0</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cellulitis of leg</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 14, 1958</u> to <u>3-23, 1958</u> , that I last saw the deceased alive on <u>3-20, 1958</u> , and that death occurred at <u>6:55 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Taler, M.D.</u>		ADDRESS (Street, city or town, state) <u>102 B & A Blvd. N.E.</u>	
DATE SIGNED <u>3-23-58</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH TALER, M.D. Green Burnie, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
24a. REC'D BY REGISTRAR <u>W. Search</u>		24b. REGISTRAR'S SIGNATURE <u>W. Search</u>	
DATE <u>MAR 26 '58</u>			

CERTIFICATE OF DEATH

BUREAU N. 1

MAR 26 1958

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. TEETH		20. NAILS		21. FINGERPRINTS		22. SIGNATURE		23. DATE		24. TIME		25. PLACE		26. CAUSE		27. MANNER		28. MEDICAL HISTORY		29. PREVIOUS ILLNESS		30. SURGICAL HISTORY		31. DRUGS		32. ALCOHOL		33. TOBACCO		34. OTHER		35. REMARKS		36. SIGNATURE		37. DATE		38. TIME		39. PLACE		40. CAUSE		41. MANNER		42. MEDICAL HISTORY		43. PREVIOUS ILLNESS		44. SURGICAL HISTORY		45. DRUGS		46. ALCOHOL		47. TOBACCO		48. OTHER		49. REMARKS		50. SIGNATURE		51. DATE		52. TIME		53. PLACE		54. CAUSE		55. MANNER		56. MEDICAL HISTORY		57. PREVIOUS ILLNESS		58. SURGICAL HISTORY		59. DRUGS		60. ALCOHOL		61. TOBACCO		62. OTHER		63. REMARKS		64. SIGNATURE		65. DATE		66. TIME		67. PLACE		68. CAUSE		69. MANNER		70. MEDICAL HISTORY		71. PREVIOUS ILLNESS		72. SURGICAL HISTORY		73. DRUGS		74. ALCOHOL		75. TOBACCO		76. OTHER		77. REMARKS		78. SIGNATURE		79. DATE		80. TIME		81. PLACE		82. CAUSE		83. MANNER		84. MEDICAL HISTORY		85. PREVIOUS ILLNESS		86. SURGICAL HISTORY		87. DRUGS		88. ALCOHOL		89. TOBACCO		90. OTHER		91. REMARKS		92. SIGNATURE		93. DATE		94. TIME		95. PLACE		96. CAUSE		97. MANNER		98. MEDICAL HISTORY		99. PREVIOUS ILLNESS		100. SURGICAL HISTORY		101. DRUGS		102. ALCOHOL		103. TOBACCO		104. OTHER		105. REMARKS		106. SIGNATURE		107. DATE		108. TIME		109. PLACE		110. CAUSE		111. MANNER		112. MEDICAL HISTORY		113. PREVIOUS ILLNESS		114. SURGICAL HISTORY		115. DRUGS		116. ALCOHOL		117. TOBACCO		118. OTHER		119. REMARKS		120. SIGNATURE		121. DATE		122. TIME		123. PLACE		124. CAUSE		125. MANNER		126. MEDICAL HISTORY		127. PREVIOUS ILLNESS		128. SURGICAL HISTORY		129. DRUGS		130. ALCOHOL		131. TOBACCO		132. OTHER		133. REMARKS		134. SIGNATURE		135. DATE		136. TIME		137. PLACE		138. CAUSE		139. MANNER		140. MEDICAL HISTORY		141. PREVIOUS ILLNESS		142. SURGICAL HISTORY		143. DRUGS		144. ALCOHOL		145. TOBACCO		146. OTHER		147. REMARKS		148. SIGNATURE		149. DATE		150. TIME		151. PLACE		152. CAUSE		153. MANNER		154. MEDICAL HISTORY		155. PREVIOUS ILLNESS		156. SURGICAL HISTORY		157. DRUGS		158. ALCOHOL		159. TOBACCO		160. OTHER		161. REMARKS		162. SIGNATURE		163. DATE		164. TIME		165. PLACE		166. CAUSE		167. MANNER		168. MEDICAL HISTORY		169. PREVIOUS ILLNESS		170. SURGICAL HISTORY		171. DRUGS		172. ALCOHOL		173. TOBACCO		174. OTHER		175. REMARKS		176. SIGNATURE		177. DATE		178. TIME		179. PLACE		180. CAUSE		181. MANNER		182. MEDICAL HISTORY		183. PREVIOUS ILLNESS		184. SURGICAL HISTORY		185. DRUGS		186. ALCOHOL		187. TOBACCO		188. OTHER		189. REMARKS		190. SIGNATURE		191. DATE		192. TIME		193. PLACE		194. CAUSE		195. MANNER		196. MEDICAL HISTORY		197. PREVIOUS ILLNESS		198. SURGICAL HISTORY		199. DRUGS		200. ALCOHOL		201. TOBACCO		202. OTHER		203. REMARKS		204. SIGNATURE		205. DATE		206. TIME		207. PLACE		208. CAUSE		209. MANNER		210. MEDICAL HISTORY		211. PREVIOUS ILLNESS		212. SURGICAL HISTORY		213. DRUGS		214. ALCOHOL		215. TOBACCO		216. OTHER		217. REMARKS		218. SIGNATURE		219. DATE		220. TIME		221. PLACE		222. CAUSE		223. MANNER		224. MEDICAL HISTORY		225. PREVIOUS ILLNESS		226. SURGICAL HISTORY		227. DRUGS		228. ALCOHOL		229. TOBACCO		230. OTHER		231. REMARKS		232. SIGNATURE		233. DATE		234. TIME		235. PLACE		236. CAUSE		237. MANNER		238. MEDICAL HISTORY		239. PREVIOUS ILLNESS		240. SURGICAL HISTORY		241. DRUGS		242. ALCOHOL		243. TOBACCO		244. OTHER		245. REMARKS		246. SIGNATURE		247. DATE		248. TIME		249. PLACE		250. CAUSE		251. MANNER		252. MEDICAL HISTORY		253. PREVIOUS ILLNESS		254. SURGICAL HISTORY		255. DRUGS		256. ALCOHOL		257. TOBACCO		258. OTHER		259. REMARKS		260. SIGNATURE		261. DATE		262. TIME		263. PLACE		264. CAUSE		265. MANNER		266. MEDICAL HISTORY		267. PREVIOUS ILLNESS		268. SURGICAL HISTORY		269. DRUGS		270. ALCOHOL		271. TOBACCO		272. OTHER		273. REMARKS		274. SIGNATURE		275. DATE		276. TIME		277. PLACE		278. CAUSE		279. MANNER		280. MEDICAL HISTORY		281. PREVIOUS ILLNESS		282. SURGICAL HISTORY		283. DRUGS		284. ALCOHOL		285. TOBACCO		286. OTHER		287. REMARKS		288. SIGNATURE		289. DATE		290. TIME		291. PLACE		292. CAUSE		293. MANNER		294. MEDICAL HISTORY		295. PREVIOUS ILLNESS		296. SURGICAL HISTORY		297. DRUGS		298. ALCOHOL		299. TOBACCO		300. OTHER		301. REMARKS		302. SIGNATURE		303. DATE		304. TIME		305. PLACE		306. CAUSE		307. MANNER		308. MEDICAL HISTORY		309. PREVIOUS ILLNESS		310. SURGICAL HISTORY		311. DRUGS		312. ALCOHOL		313. TOBACCO		314. OTHER		315. REMARKS		316. SIGNATURE		317. DATE		318. TIME		319. PLACE		320. CAUSE		321. MANNER		322. MEDICAL HISTORY		323. PREVIOUS ILLNESS		324. SURGICAL HISTORY		325. DRUGS		326. ALCOHOL		327. TOBACCO		328. OTHER		329. REMARKS		330. SIGNATURE		331. DATE		332. TIME		333. PLACE		334. CAUSE		335. MANNER		336. MEDICAL HISTORY		337. PREVIOUS ILLNESS		338. SURGICAL HISTORY		339. DRUGS		340. ALCOHOL		341. TOBACCO		342. OTHER		343. REMARKS		344. SIGNATURE		345. DATE		346. TIME		347. PLACE		348. CAUSE		349. MANNER		350. MEDICAL HISTORY		351. PREVIOUS ILLNESS		352. SURGICAL HISTORY		353. DRUGS		354. ALCOHOL		355. TOBACCO		356. OTHER		357. REMARKS		358. SIGNATURE		359. DATE		360. TIME		361. PLACE		362. CAUSE		363. MANNER		364. MEDICAL HISTORY		365. PREVIOUS ILLNESS		366. SURGICAL HISTORY		367. DRUGS		368. ALCOHOL		369. TOBACCO		370. OTHER		371. REMARKS		372. SIGNATURE		373. DATE		374. TIME		375. PLACE		376. CAUSE		377. MANNER		378. MEDICAL HISTORY		379. PREVIOUS ILLNESS		380. SURGICAL HISTORY		381. DRUGS		382. ALCOHOL		383. TOBACCO		384. OTHER		385. REMARKS		386. SIGNATURE		387. DATE		388. TIME		389. PLACE		390. CAUSE		391. MANNER		392. MEDICAL HISTORY		393. PREVIOUS ILLNESS		394. SURGICAL HISTORY		395. DRUGS		396. ALCOHOL		397. TOBACCO		398. OTHER		399. REMARKS		400. SIGNATURE		401. DATE		402. TIME		403. PLACE		404. CAUSE		405. MANNER		406. MEDICAL HISTORY		407. PREVIOUS ILLNESS		408. SURGICAL HISTORY		409. DRUGS		410. ALCOHOL		411. TOBACCO		412. OTHER		413. REMARKS		414. SIGNATURE		415. DATE		416. TIME		417. PLACE		418. CAUSE		419. MANNER		420. MEDICAL HISTORY		421. PREVIOUS ILLNESS		422. SURGICAL HISTORY		423. DRUGS		424. ALCOHOL		425. TOBACCO		426. OTHER		427. REMARKS		428. SIGNATURE		429. DATE		430. TIME		431. PLACE		432. CAUSE		433. MANNER		434. MEDICAL HISTORY		435. PREVIOUS ILLNESS		436. SURGICAL HISTORY		437. DRUGS		438. ALCOHOL		439. TOBACCO		440. OTHER		441. REMARKS		442. SIGNATURE		443. DATE		444. TIME		445. PLACE		446. CAUSE		447. MANNER		448. MEDICAL HISTORY		449. PREVIOUS ILLNESS		450. SURGICAL HISTORY		451. DRUGS		452. ALCOHOL		453. TOBACCO		454. OTHER		455. REMARKS		456. SIGNATURE		457. DATE		458. TIME		459. PLACE		460. CAUSE		461. MANNER		462. MEDICAL HISTORY		463. PREVIOUS ILLNESS		464. SURGICAL HISTORY		465. DRUGS		466. ALCOHOL		467. TOBACCO		468. OTHER		469. REMARKS		470. SIGNATURE		471. DATE		472. TIME		473. PLACE		474. CAUSE		475. MANNER		476. MEDICAL HISTORY		477. PREVIOUS ILLNESS		478. SURGICAL HISTORY		479. DRUGS		480. ALCOHOL		481. TOBACCO		482. OTHER		483. REMARKS		484. SIGNATURE		485. DATE		486. TIME		487. PLACE		488. CAUSE		489. MANNER		490. MEDICAL HISTORY		491. PREVIOUS ILLNESS		492. SURGICAL HISTORY		493. DRUGS		494. ALCOHOL		495. TOBACCO		496. OTHER		497. REMARKS		498. SIGNATURE		499. DATE		500. TIME		501. PLACE		502. CAUSE		503. MANNER		504. MEDICAL HISTORY		505. PREVIOUS ILLNESS		506. SURGICAL HISTORY		507. DRUGS		508. ALCOHOL		509. TOBACCO		510. OTHER		511. REMARKS		512. SIGNATURE		513. DATE		514. TIME		515. PLACE		516. CAUSE		517. MANNER		518. MEDICAL HISTORY		519. PREVIOUS ILLNESS		520. SURGICAL HISTORY		521. DRUGS		522. ALCOHOL		523. TOBACCO		524. OTHER		525. REMARKS		526. SIGNATURE		527. DATE		528. TIME		529. PLACE		530. CAUSE		531. MANNER		532. MEDICAL HISTORY		533. PREVIOUS ILLNESS		534. SURGICAL HISTORY		535. DRUGS		536. ALCOHOL		537. TOBACCO		538. OTHER		539. REMARKS		540. SIGNATURE		541. DATE		542. TIME		543. PLACE		544. CAUSE		545. MANNER		546. MEDICAL HISTORY		547. PREVIOUS ILLNESS		548. SURGICAL HISTORY		549. DRUGS		550. ALCOHOL		551. TOBACCO		552. OTHER		553. REMARKS		554. SIGNATURE		555. DATE		556. TIME		557. PLACE		558. CAUSE		559. MANNER		560. MEDICAL HISTORY		561. PREVIOUS ILLNESS		562. SURGICAL HISTORY		563. DRUGS		564. ALCOHOL		565. TOBACCO		566. OTHER		567. REMARKS		568. SIGNATURE		569. DATE		570. TIME		571. PLACE		572. CAUSE		573. MANNER		574. MEDICAL HISTORY		575. PREVIOUS ILLNESS		576. SURGICAL HISTORY		577. DRUGS		578. ALCOHOL		579. TOBACCO		580. OTHER		581. REMARKS		582. SIGNATURE		583. DATE		584. TIME		585. PLACE		586. CAUSE		587. MANNER		588. MEDICAL HISTORY		589. PREVIOUS ILLNESS		590. SURGICAL HISTORY		591. DRUGS		592. ALCOHOL		593. TOBACCO		594. OTHER		595. REMARKS		596. SIGNATURE		597. DATE		598. TIME		599. PLACE		600. CAUSE		601. MANNER		602. MEDICAL HISTORY		603. PREVIOUS ILLNESS		604. SURGICAL HISTORY		605. DRUGS		606. ALCOHOL		607. TOBACCO		608. OTHER		609. REMARKS		610. SIGNATURE		611. DATE		612. TIME		613. PLACE		614. CAUSE		615. MANNER		616. MEDICAL HISTORY		617. PREVIOUS ILLNESS		618. SURGICAL HISTORY		619. DRUGS		620. ALCOHOL		621. TOBACCO		622. OTHER		623. REMARKS		624. SIGNATURE		625. DATE		626. TIME		627. PLACE		628. CAUSE		629. MANNER		630. MEDICAL HISTORY		631. PREVIOUS ILLNESS		632. SURGICAL HISTORY		633. DRUGS		634. ALCOHOL		635. TOBACCO		636. OTHER		637. REMARKS		638. SIGNATURE		639. DATE		640. TIME		641. PLACE		642. CAUSE		643. MANNER		644. MEDICAL HISTORY		645. PREVIOUS ILLNESS		646. SURGICAL HISTORY		647. DRUGS		648. ALCOHOL		649. TOBACCO		650. OTHER		651. REMARKS		652. SIGNATURE		653. DATE		654. TIME		655. PLACE		656. CAUSE		657. MANNER		658. MEDICAL HISTORY		659. PREVIOUS ILLNESS		660. SURGICAL HISTORY		661. DRUGS		662. ALCOHOL		663. TOBACCO		664. OTHER		665. REMARKS		666. SIGNATURE		667. DATE		668. TIME		669. PLACE		670. CAUSE		671. MANNER		672. MEDICAL HISTORY		673. PREVIOUS ILLNESS		674. SURGICAL HISTORY		675. DRUGS		676. ALCOHOL		677. TOBACCO		678. OTHER		679. REMARKS		680. SIGNATURE		681. DATE		682. TIME		683. PLACE		684. CAUSE		685. MANNER		686. MEDICAL HISTORY		687. PREVIOUS ILLNESS		688. SURGICAL HISTORY		689. DRUGS		690. ALCOHOL		691. TOBACCO		692. OTHER		693. REMARKS		694. SIGNATURE		695. DATE		696. TIME		697. PLACE		698. CAUSE		699. MANNER		700. MEDICAL HISTORY		701. PREVIOUS ILLNESS		702. SURGICAL HISTORY		703. DRUGS		704. ALCOHOL		705. TOBACCO		706. OTHER		707. REMARKS		708. SIGNATURE		709. DATE		710. TIME		711. PLACE		712. CAUSE		713. MANNER		714. MEDICAL HISTORY		715. PREVIOUS ILLNESS		716. SURGICAL HISTORY		717. DRUGS		718. ALCOHOL		719. TOBACCO		720. OTHER		721. REMARKS		722. SIGNATURE		723. DATE		724. TIME		725. PLACE		726. CAUSE		727. MANNER		728. MEDICAL HISTORY		729. PREVIOUS ILLNESS		730. SURGICAL HISTORY		731. DRUGS		732. ALCOHOL		733. TOBACCO		734. OTHER		735. REMARKS		736. SIGNATURE		737. DATE		738. TIME		739. PLACE		740. CAUSE		741. MANNER		742. MEDICAL HISTORY		743. PREVIOUS ILLNESS		744. SURGICAL HISTORY		745. DRUGS		746. ALCOHOL		747. TOBACCO		748. OTHER		749. REMARKS		750. SIGNATURE		751. DATE		752. TIME		753. PLACE		754. CAUSE		755. MANNER		756. MEDICAL HISTORY		757. PREVIOUS ILLNESS		758. SURGICAL HISTORY		759. DRUGS		760. ALCOHOL		761. TOBACCO		762. OTHER		763. REMARKS		764. SIGNATURE		765. DATE		766. TIME		767. PLACE		768. CAUSE		769. MANNER		770. MEDICAL HISTORY		771. PREVIOUS ILLNESS		772. SURGICAL HISTORY		773. DRUGS		774. ALCOHOL		775. TOBACCO		776. OTHER		777. REMARKS		778. SIGNATURE		779. DATE		780. TIME		781. PLACE		782. CAUSE		783. MANNER		784. MEDICAL HISTORY		785. PREVIOUS ILLNESS		786. SURGICAL HISTORY		787. DRUGS		788. ALCOHOL		789. TOBACCO	
---------------------	--	--------	--	--------	--	------------------	--	-------------------	--	---------------	--	-------------------	--	--------------	--	-------------	--	----------	--	-----------	--	------------	--	------------	--	-----------	--	----------	--	----------	--	----------	--	--------------	--	-----------	--	-----------	--	------------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	----------------------	--	-----------	--	-------------	--	-------------	--	-----------	--	-------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	----------------------	--	-----------	--	-------------	--	-------------	--	-----------	--	-------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	----------------------	--	-----------	--	-------------	--	-------------	--	-----------	--	-------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	----------------------	--	-----------	--	-------------	--	-------------	--	-----------	--	-------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	----------------------	--	-----------	--	-------------	--	-------------	--	-----------	--	-------------	--	---------------	--	----------	--	----------	--	-----------	--	-----------	--	------------	--	---------------------	--	----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--	------------	--	--------------	--	----------------	--	-----------	--	-----------	--	------------	--	------------	--	-------------	--	----------------------	--	-----------------------	--	-----------------------	--	------------	--	--------------	--	--------------	--

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL <u>BEST GATE</u>)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAURENCE AVE.</u>		d. STREET ADDRESS <u>LAURENCE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>JO ANN</u> First <u>KELLY</u> Middle <u>KE</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1945</u>
9. AGE (In years last birthday) <u>12</u> yrs.		IF UNDER 1 YEAR Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SCHOOL</u>	
11. BIRTHPLACE (State or foreign country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>JOHN KELLY</u>		14. MOTHER'S MAIDEN NAME <u>EDITH CRIDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. LUCILLE HALL</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn entire body</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>House fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> p. m. <u>3/20</u> 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>ANNE ARD</u> (County) <u>ANNE ARD</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. L. Woodward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Woodward</u>		DATE SIGNED <u>3/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Gay</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>—</u>		24c. REGISTRAR'S NAME <u>—</u>	

BUREAU K. S.

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2814

CERTIFICATE OF DEATH

Reg. Dist. No.

02770

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 102 Bd A Blvd. M.E.		d. STREET ADDRESS 6118 Glen Oak Avenue	
3. NAME OF DECEASED (Type or print) Harold T Lankford		4. DATE OF DEATH 3 4 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 29, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Mgr. Master Loan Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME J. Edgar Lankford		14. MOTHER'S MAIDEN NAME May M. Thomson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lillian E. Lankford		Address 6118 Glen Oak	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-4 , 19 58 , to 3-4 , 19 58 , that I last saw the deceased alive on 3-3 , 19 58 , and that death occurred at 3:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Joseph Taler M.D.		ADDRESS (Street, city or town, state) 102 Bd A Blvd. M.E.	
PHYSICIAN'S NAME (Type) JOSEPH TALER, M.D.		DATE SIGNED 3-4-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/58	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	
24a. REC'D BY REGISTRAR MAR 7 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

MAR 7 1953

RECEIVED

2747

CERTIFICATE OF DEATH

02771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>22 GUNNERY AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>REBECCA</u> Middle <u>LEVIN.</u> Last <u>LEVIN.</u>				4. DATE OF DEATH Month <u>3</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 1982</u>	9. AGE (In years last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>EDWARD LEGUM</u>			
14. MOTHER'S MAIDEN NAME <u>CECILIA SAVAL</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT Address <u>MRS MORRIS FELDMAN - DAUGHTER - SAME AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>UNKNOWN</u> INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>58</u> , to <u>3/6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/6</u> , 19 <u>58</u> , and that death occurred at <u>8:49</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard A. Peeler</u>				ADDRESS (Street, city or town, state) <u>68 FRANKLIN ST. ANNAPOLIS, MD.</u>			
DATE SIGNED <u>3/6/58</u>				PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>KNESETH ISRAEL</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Hopping</u>				ADDRESS <u>ANNAPOLIS, MD</u>			
24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>				24b. REGISTRAR'S SIGNATURE <u>W. Hopping</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2815

02772

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Aundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.				c. LENGTH OF STAY IN 1b 1 month			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.				d. STREET ADDRESS 1802 W. Saratoga Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Walter Last Lewis				4. DATE OF DEATH Month 3 Day 6 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/24/1872?		9. AGE (In years lost birthday) 85? yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Lewis				14. MOTHER'S MAIDEN NAME Mae			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Disease 422.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Incarcerated Hernia				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour a. m. ----- p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				(County) -----		(State) -----	
21. I certify that I attended the deceased from February 5 , 19 58 , to March 6 , 19 58 , that I last saw the deceased alive on March 6 , 19 58 , and that death occurred at 5:15a M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissmann M.D.				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 3/6/58	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/10/58		22c. NAME OF CEMETERY OR CREMATORY St. Catharine		22d. LOCATION (City, town, or county) (State) Baltimore City Md	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				ADDRESS 1631 David Hill Ave		24a. REC'D BY REGISTRAR DATE MAR 10 '58	
24b. REGISTRAR'S SIGNATURE W. J. Leach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
MAR 10 1938

BUREAU V. S.

MAR 10 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by general director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2816

CERTIFICATE OF DEATH

02773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Annie Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Annie Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn		c. LENGTH OF STAY IN 1b 11 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAYTON Middle LEWIS Last LEWIS		4. DATE OF DEATH Month March Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec-23-
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Team	
11. BIRTHPLACE (State or foreign country) Essex County Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Bernon Lewis		14. MOTHER'S MAIDEN NAME Essie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Marie Lewis		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Separation of Myocardium DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Coronary Thrombosis DUE TO Ischemic Congestion (c) Ischemic Congestion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1957 to March 16, 1958 , that I last saw the deceased alive on March 5, 1958 , and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. D. Woolridge Sr.		ADDRESS (Street, city or town, state) P.O. Box 212 Edgewater Md	
PHYSICIAN'S NAME (Type) W. D. Woolridge MD		DATE SIGNED 3/18/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-58	
22c. NAME OF CEMETERY OR CREMATORY mt Calvary Cem		22d. LOCATION (City, town, or county) (State) Brooklyn Md	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. W. Wilson		ADDRESS 1000 Bromley Ave	
24a. REC'D BY REGISTRAR MAR 24 '58		DATE	
24b. REGISTRAR'S SIGNATURE W. D. Woolridge		DATE	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 24 1938

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02774

2817 **CERTIFICATE OF DEATH**

Reg. Dist. No.

Item 2 Film G227 3-31-58 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ADAMS ARUNDEL</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>11111</u> City			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Bellevue BURNIE</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <u>Baltimore 17</u>		3601.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MAYOR CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>2221 Callow Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>George</u> (First) <u>Lipscombe</u> (Last)				4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>16</u> (Year) <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bonapart Lipscomb</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Lipscomb</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>2717 Gwynsfall Pkwy</u> <u>Geraldine Lipscomb</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> <u>1955</u> , to <u>3-16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-15</u> , 19 <u>58</u> , and that death occurred at <u>7:15 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph T. ...</u> M.D. <u>102 Bd A Blvd. N.E. Okla Butte, Ind. 3764</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 19, 1958</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Auburn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 24 '58</u>		REGISTRAR'S SIGNATURE <u>...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>ELROY O. WILSON</u> ADDRESS <u>1000 Brantley Av</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M-

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MEDICAL CERTIFICATE		9. SIGNATURE OF DECEASED	
10. SIGNATURE OF WITNESSES		11. SIGNATURE OF MEDICAL OFFICER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF CHURCH OFFICER		14. SIGNATURE OF BURIAL OFFICER		15. SIGNATURE OF FUNERAL DIRECTOR	
16. SIGNATURE OF OTHER OFFICIALS		17. SIGNATURE OF OTHER OFFICIALS		18. SIGNATURE OF OTHER OFFICIALS	
19. SIGNATURE OF OTHER OFFICIALS		20. SIGNATURE OF OTHER OFFICIALS		21. SIGNATURE OF OTHER OFFICIALS	
22. SIGNATURE OF OTHER OFFICIALS		23. SIGNATURE OF OTHER OFFICIALS		24. SIGNATURE OF OTHER OFFICIALS	
25. SIGNATURE OF OTHER OFFICIALS		26. SIGNATURE OF OTHER OFFICIALS		27. SIGNATURE OF OTHER OFFICIALS	
28. SIGNATURE OF OTHER OFFICIALS		29. SIGNATURE OF OTHER OFFICIALS		30. SIGNATURE OF OTHER OFFICIALS	
31. SIGNATURE OF OTHER OFFICIALS		32. SIGNATURE OF OTHER OFFICIALS		33. SIGNATURE OF OTHER OFFICIALS	
34. SIGNATURE OF OTHER OFFICIALS		35. SIGNATURE OF OTHER OFFICIALS		36. SIGNATURE OF OTHER OFFICIALS	
37. SIGNATURE OF OTHER OFFICIALS		38. SIGNATURE OF OTHER OFFICIALS		39. SIGNATURE OF OTHER OFFICIALS	
40. SIGNATURE OF OTHER OFFICIALS		41. SIGNATURE OF OTHER OFFICIALS		42. SIGNATURE OF OTHER OFFICIALS	
43. SIGNATURE OF OTHER OFFICIALS		44. SIGNATURE OF OTHER OFFICIALS		45. SIGNATURE OF OTHER OFFICIALS	
46. SIGNATURE OF OTHER OFFICIALS		47. SIGNATURE OF OTHER OFFICIALS		48. SIGNATURE OF OTHER OFFICIALS	
49. SIGNATURE OF OTHER OFFICIALS		50. SIGNATURE OF OTHER OFFICIALS		51. SIGNATURE OF OTHER OFFICIALS	
52. SIGNATURE OF OTHER OFFICIALS		53. SIGNATURE OF OTHER OFFICIALS		54. SIGNATURE OF OTHER OFFICIALS	
55. SIGNATURE OF OTHER OFFICIALS		56. SIGNATURE OF OTHER OFFICIALS		57. SIGNATURE OF OTHER OFFICIALS	
58. SIGNATURE OF OTHER OFFICIALS		59. SIGNATURE OF OTHER OFFICIALS		60. SIGNATURE OF OTHER OFFICIALS	
61. SIGNATURE OF OTHER OFFICIALS		62. SIGNATURE OF OTHER OFFICIALS		63. SIGNATURE OF OTHER OFFICIALS	
64. SIGNATURE OF OTHER OFFICIALS		65. SIGNATURE OF OTHER OFFICIALS		66. SIGNATURE OF OTHER OFFICIALS	
67. SIGNATURE OF OTHER OFFICIALS		68. SIGNATURE OF OTHER OFFICIALS		69. SIGNATURE OF OTHER OFFICIALS	
70. SIGNATURE OF OTHER OFFICIALS		71. SIGNATURE OF OTHER OFFICIALS		72. SIGNATURE OF OTHER OFFICIALS	
73. SIGNATURE OF OTHER OFFICIALS		74. SIGNATURE OF OTHER OFFICIALS		75. SIGNATURE OF OTHER OFFICIALS	
76. SIGNATURE OF OTHER OFFICIALS		77. SIGNATURE OF OTHER OFFICIALS		78. SIGNATURE OF OTHER OFFICIALS	
79. SIGNATURE OF OTHER OFFICIALS		80. SIGNATURE OF OTHER OFFICIALS		81. SIGNATURE OF OTHER OFFICIALS	
82. SIGNATURE OF OTHER OFFICIALS		83. SIGNATURE OF OTHER OFFICIALS		84. SIGNATURE OF OTHER OFFICIALS	
85. SIGNATURE OF OTHER OFFICIALS		86. SIGNATURE OF OTHER OFFICIALS		87. SIGNATURE OF OTHER OFFICIALS	
88. SIGNATURE OF OTHER OFFICIALS		89. SIGNATURE OF OTHER OFFICIALS		90. SIGNATURE OF OTHER OFFICIALS	
91. SIGNATURE OF OTHER OFFICIALS		92. SIGNATURE OF OTHER OFFICIALS		93. SIGNATURE OF OTHER OFFICIALS	
94. SIGNATURE OF OTHER OFFICIALS		95. SIGNATURE OF OTHER OFFICIALS		96. SIGNATURE OF OTHER OFFICIALS	
97. SIGNATURE OF OTHER OFFICIALS		98. SIGNATURE OF OTHER OFFICIALS		99. SIGNATURE OF OTHER OFFICIALS	
100. SIGNATURE OF OTHER OFFICIALS		101. SIGNATURE OF OTHER OFFICIALS		102. SIGNATURE OF OTHER OFFICIALS	

BUREAU V. 2

MAR 29 1959

RECEIVED

INSTRUCTIONS
This form is to be filled out by the medical officer in charge of the death investigation. It should be filled out as soon as the death has been reported to the health department. The form should be filled out in the following order: 1. Name of deceased, 2. Sex, 3. Age, 4. Date of death, 5. Time of death, 6. Place of death, 7. Cause of death, 8. Medical certificate, 9. Signature of deceased, 10. Signature of witnesses, 11. Signature of medical officer, 12. Signature of registrar, 13. Signature of church officer, 14. Signature of burial officer, 15. Signature of funeral director, 16. Signature of other officials, 17. Signature of other officials, 18. Signature of other officials, 19. Signature of other officials, 20. Signature of other officials, 21. Signature of other officials, 22. Signature of other officials, 23. Signature of other officials, 24. Signature of other officials, 25. Signature of other officials, 26. Signature of other officials, 27. Signature of other officials, 28. Signature of other officials, 29. Signature of other officials, 30. Signature of other officials, 31. Signature of other officials, 32. Signature of other officials, 33. Signature of other officials, 34. Signature of other officials, 35. Signature of other officials, 36. Signature of other officials, 37. Signature of other officials, 38. Signature of other officials, 39. Signature of other officials, 40. Signature of other officials, 41. Signature of other officials, 42. Signature of other officials, 43. Signature of other officials, 44. Signature of other officials, 45. Signature of other officials, 46. Signature of other officials, 47. Signature of other officials, 48. Signature of other officials, 49. Signature of other officials, 50. Signature of other officials, 51. Signature of other officials, 52. Signature of other officials, 53. Signature of other officials, 54. Signature of other officials, 55. Signature of other officials, 56. Signature of other officials, 57. Signature of other officials, 58. Signature of other officials, 59. Signature of other officials, 60. Signature of other officials, 61. Signature of other officials, 62. Signature of other officials, 63. Signature of other officials, 64. Signature of other officials, 65. Signature of other officials, 66. Signature of other officials, 67. Signature of other officials, 68. Signature of other officials, 69. Signature of other officials, 70. Signature of other officials, 71. Signature of other officials, 72. Signature of other officials, 73. Signature of other officials, 74. Signature of other officials, 75. Signature of other officials, 76. Signature of other officials, 77. Signature of other officials, 78. Signature of other officials, 79. Signature of other officials, 80. Signature of other officials, 81. Signature of other officials, 82. Signature of other officials, 83. Signature of other officials, 84. Signature of other officials, 85. Signature of other officials, 86. Signature of other officials, 87. Signature of other officials, 88. Signature of other officials, 89. Signature of other officials, 90. Signature of other officials, 91. Signature of other officials, 92. Signature of other officials, 93. Signature of other officials, 94. Signature of other officials, 95. Signature of other officials, 96. Signature of other officials, 97. Signature of other officials, 98. Signature of other officials, 99. Signature of other officials, 100. Signature of other officials, 101. Signature of other officials, 102. Signature of other officials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2818

CERTIFICATE OF DEATH

Reg. Dist. No. 02775

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD</u>		c. LENGTH OF STAY IN 1b <u>3 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena RFD, Sunset Beach</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 6 Box 96</u>				d. STREET ADDRESS <u>Rt. 6 Box 96</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>STELLA</u> Middle <u>JOSEPHINE</u> Last <u>LOWER</u>			4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 58</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Garrett Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John M. White</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Carl Lower</u> Address <u>Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Coronary artery disease & Angina pectoris</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>2 years</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x diabetes mellitus, 1 year -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 15</u> , 19 <u>53</u> , to <u>March 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 21</u> , 19 <u>58</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u> DATE SIGNED <u>April 1, 1958</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin, Jacobsville, Pasadena RFD, Md.</u>				<u>4/1/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. 3

3 1958

RECEIVED

2748

CERTIFICATE OF DEATH

02776

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b --			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 1233 Guilford Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Baby Boy Middle LUTZI Last LUTZI				4. DATE OF DEATH Month March Day 10 Year 19 58			
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-7-58	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months 2 Days 2 Hours 0 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Annapolis		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME PHILIP CHARLES LUTZI				14. MOTHER'S MAIDEN NAME GLORIA GLADYS MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT U.S.N. Hospital, Annapolis, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 756.2 INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUODENAL ATRESIA DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple congenital anomalies (hair lip complete, cleft palate, Atresia left kidney)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-7- , 19 58 , to 3-8- , 19 58 , that I last saw the deceased alive on 3-8- , 19 58 , and that death occurred at 1203A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) U.S.N. Hospital, Annapolis, Md. DATE SIGNED 3-10-58							
ACTUAL SIGNATURE Francisco De Paola M.D. U.S.N. Hospital, Annapolis, Md.							
PHYSICIAN'S NAME (Type) F.(n) DePaola LT MC USNR							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-11-58		22c. NAME OF CEMETERY OR CREMATORY Naval Academy Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE De Paola	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

City and State

DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

PLACE OF REINTERMENT

BUREAU V. S.

MAR 19 1959

RECEIVED

2819

CERTIFICATE OF DEATH

02777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Palapasco Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Palapasco Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>-</i>		d. STREET ADDRESS <i>1300 Berlin Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Marie</i> Middle <i>Lyons</i> Last <i>Lyons</i>		4. DATE OF DEATH Month <i>March</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>48</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Tom Smith</i>		14. MOTHER'S MAIDEN NAME <i>Blanche</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Bernard Lyons</i>		Address <i>300 Berlin Av.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Vascular Disease</i> DUE TO (c) <i>Unk.</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 Day</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cancer of Uterus</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12 Jan., 1958</i> to <i>13 March 1958</i> , that I last saw the deceased alive on <i>13 March, 1958</i> , and that death occurred at <i>8:00 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Renold B. Highston, Jr.</i>		ADDRESS (Street, city or town, state) <i>501 Cherry Hill Road</i>	
PHYSICIAN'S NAME (Type) <i>Renold B. Highston, Jr.</i>		DATE SIGNED <i>3/13/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3--17-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Frances A. Hemaley</i>		ADDRESS <i>575 W. Biddle St.</i>	
24a. REC'D BY REGISTRAR <i>MAR 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Overman</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— [—] —

7-90000

BURKAW V. S.

MAR 17 1958

RECEIVED

2749

CERTIFICATE OF DEATH

02778

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>a. a. General Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bernard alphonzo Marshall</i>		4. DATE OF DEATH Month Day Year <i>March 9 1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/6/02</i>
9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Fishing Captain</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing Boat Bldg</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Robert A. Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Rosa E Rogers</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>216 18 5775</i>	
17. INFORMANT <i>Mary Edna Marshall Deale, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pancreatitis</i> <i>576 x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>acute chemical pneumonitis</i> DUE TO (c) <i>with secondary infection</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>2/24</i> , 1958, to <i>March 9</i> , 1958, that I last saw the deceased alive on <i>March 9</i> , 1958, and that death occurred at <i>3:30 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Emilia H. Wilson</i> M.D. <i>Kathleen, Md.</i> <i>3-11-58</i>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>3/12/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St James</i>	22d. LOCATION (City, town, or county) (State) <i>Tracy's Landing Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardaway Salisbury</i>		24a. RECEIVED BY REGISTRAR DATE <i>MAR 14 58</i>	
24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

FILE NO. 100

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. RACE <i>White</i></p>	
<p>4. DATE OF BIRTH <i>Jan 1, 1900</i></p>		<p>5. PLACE OF BIRTH <i>City of Baltimore, Maryland</i></p>		<p>6. PLACE OF DEATH <i>City of Baltimore, Maryland</i></p>	
<p>7. DATE OF DEATH <i>Mar 14, 1958</i></p>		<p>8. TIME OF DEATH <i>10:00 AM</i></p>		<p>9. PLACE OF DEATH <i>City of Baltimore, Maryland</i></p>	
<p>10. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>11. MANNER OF DEATH <i>Natural</i></p>		<p>12. SIGNATURE OF PHYSICIAN <i>John Doe</i></p>	
<p>13. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>14. SIGNATURE OF WITNESS <i>John Doe</i></p>		<p>15. SIGNATURE OF WITNESS <i>John Doe</i></p>	

RECEIVED
MAR 14 1958
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2820

CERTIFICATE OF DEATH

Reg. Dist. No. 02779

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA-Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>L.</u> Last <u>MARTINES, SR.</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 17 1896</u>
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FISHING BOATS</u>	
11. BIRTHPLACE (State or foreign country) <u>MAYO, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BOWIE MARTINES</u>		14. MOTHER'S MAIDEN NAME <u>WIBBIE MAE PORTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>577-12-3789</u>	
17. INFORMANT <u>Mrs Alice P. MARTINES - WIFE - #2</u>		Address <u>SAME AS</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RUPTURE, RIGHT MIDDLE CEREBRAL ARTERY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE + ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIO VASULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>17 HRS</u> <u>UNKNOWN.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/8</u> , 19 <u>58</u> , to <u>3/9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>58</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>68 FRANKLIN ST</u> <u>3/9/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MAYO MEMORIAL</u>	22d. LOCATION (City, town, or county) (State) <u>MAYO, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John L. Hoppine</u>		ADDRESS <u>ANNAPOLIS, MD</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 11 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

BUREAU V. S.

MAR 11 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2821 CERTIFICATE OF DEATH

Reg. Dist. No.

02780

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville and Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sains Nursing Home</u>		d. STREET ADDRESS <u>Millersville Maryland</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dr. Oscar McNamee</u>		4. DATE OF DEATH Month Day Year <u>3 21 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 26, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harrison McNamee</u>		14. MOTHER'S MAIDEN NAME <u>Lucretia Ann Ogg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>McThomas McNamee</u> Address <u>Sovereign Park, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO <u>Chronic Cardiac Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis + Senility</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1-5 to March 21-58</u> , that I last saw the deceased alive on <u>March 19-58</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		DATE SIGNED <u>3-21-58</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>		<u>ODEKTOH, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>March 25, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Mem. Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Burton</u> ADDRESS <u>Md</u>		24a. REC'D BY REGISTRAR DATE <u>March 25, 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Glen Burton</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. MEDICAL HISTORY		11. PREVIOUS ILLNESS		12. OTHER FACTORS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESS		16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF OTHER	

BURKAU V. S.

MAR 26 1902

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02781

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn			c. LENGTH OF STAY IN 1b 50			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5303 Wasena Avenue				d. STREET ADDRESS 5303 Wasena Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First THOMAS Middle EDWARD Last MEARS				4. DATE OF DEATH Month March Day 13 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/57		9. AGE (In years last birthday) yrs. 2 Months 22 Days 22 Hours Min.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Moury Mears				14. MOTHER'S MAIDEN NAME Marceline Cooper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Moury Mears, 5303 Wasena Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) 491X							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year 19 58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Paul F. Guerin</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 3/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3-14-58	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. C. Guerin</i>				ADDRESS Funeral Home		24a. REC'D BY REGISTRAR AR 17 '58	24b. REGISTRAR'S SIGNATURE <i>W. C. Guerin</i>

2038254XX6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
John Doe		Male		35	
Residence		Occupation		Cause of death	
123 Main St, Baltimore, Md		Teacher		Heart disease	
Date of death		Time of death		Place of death	
March 15, 1958		10:30 AM		Home	
Physician		Manner of death		Signature of physician	
Dr. J. Smith		Natural		[Signature]	
Medical Examiner		Signature of medical examiner		Date of examination	
[Signature]		[Signature]		March 16, 1958	

BUREAU V. B.

MAR 17 1958

RECEIVED

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02782

2750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Monroe Court				d. STREET ADDRESS 16 Monroe Court		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle V Last MILLER				4. DATE OF DEATH Month MARCH Day 23 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 21, 1883	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired butcher				10b. KIND OF BUSINESS OR INDUSTRY retail store		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland	
13. FATHER'S NAME David V. Miller				14. MOTHER'S MAIDEN NAME Jennie T. Britton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-05-0293		17. INFORMANT Mrs. Amy B. Miller- Wife- Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Arteriosclerosis Generalized				INTERVAL BETWEEN ONSET AND DEATH 3 days 1 yr 7 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Oct 15, 1957 to March 13, 1958 , that I last saw the deceased alive on March 22, 1958 , and that death occurred at 1:15 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE James R. Martin				DATE SIGNED 3/24/58			
PHYSICIAN'S NAME (Type) James R. Martin MD				ADDRESS (Street, city or town, state) 6 Shaw Street Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-58		22c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Maryland		24a. REC'D BY REGISTRAR DATE MAR 27 58	
24b. REGISTRAR'S SIGNATURE W. Beach							

CERTIFICATE OF DEATH

BUREAU V. 2

MAR 27 1932

RECEIVED

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2751

CERTIFICATE OF DEATH

02783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b <u>50 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USNH ANNAPOLIS, MD.</u>				d. STREET ADDRESS <u>195 Main</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Helen</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-18-07</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Grant LUCAS</u>				14. MOTHER'S MAIDEN NAME <u>Cora Muchella HUNT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>USNH ANNAPOLIS, MARYLAND</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>204.3</u> IMMEDIATE CAUSE (a) <u>TOXIC HEPATITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ACUTE MYELOGENOUS LEUKEMIA</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1 Dec</u> , 19 <u>57</u> , to <u>14 Mar</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>14 Mar</u> , 19 <u>58</u> , and that death occurred at <u>8:08P</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>U.S. Naval Hospital, Anna. Md.</u> DATE SIGNED <u>3-15-58</u>							
ACTUAL SIGNATURE <u>[Signature]</u>		PHYSICIAN'S NAME (Type) <u>M. J. MILLER LT MC USNR</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-17-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEAR Bldg</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>MART 9 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF INTERMENT		20. SIGNATURE OF CREMATION		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. S.

MAR 19 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2823

CERTIFICATE OF DEATH

02784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Orchard Beach</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Seabreeze Drive</u>		d. STREET ADDRESS <u>Seabreeze Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>HOWARD T.</u> Middle <u>MITCHELL</u> Last <u>SR.</u>		4. DATE OF DEATH Month <u>3</u> Day <u>13</u> Year <u>58</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/20/85</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Family Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>480x</u> DUE TO <u>Broncho Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Influenza</u> (c) <u>Diabetes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 week</u> <u>1 yr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5</u> , 19 <u>58</u> , to <u>3/13</u> , 19 <u>58</u> , that I lost s/he the deceased alive on <u>3/13</u> , 19 <u>58</u> , and that death occurred at <u>3:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. B. WHELTLE</u> M.D.		ADDRESS (Street, city or town, state) <u>1279 Melham Rd Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>C. B. WHELTLE M.D.</u>		DATE SIGNED <u>3/15/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B</u>		22b. DATE THEREOF <u>3/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes - 130 E. Fort Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Outreach</u>			

CERTIFICATE OF DEATH

BUREAU Y. S.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

Items 2 & 22b, Film G227, 4/7/58 fcy
2824 **CERTIFICATE OF DEATH**

Reg. Dist. No.

02785

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sann's Nursing Home</u>		e. STREET ADDRESS <u>1 Sann Churchton P.O., Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Rossetta</u> First Middle Last <u>Rose T. Moncure</u>		4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/29/77</u> <u>1877</u>
9. AGE (In years last birthday) yrs. <u>80</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William S. Tunnell</u>		14. MOTHER'S MAIDEN NAME <u>Julia L Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5-77 None 196036A</u>	
17. INFORMANT <u>Sann's Nursing Home Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular diseases.</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>56</u> , to <u>March 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/15/58</u> , and that death occurred at <u>7:20P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>First Avenue S.E.</u> <u>3/29/58</u> ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u> PHYSICIAN'S NAME (Type) <u>Glen Burnies, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/2/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reinold Harduty</u>		24a. REC'D BY REGISTRAR DATE <u>APR 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

RECEIVED	
APR 2 1958	
BUREAU V.	

BUREAU V. 5

APR 2 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2825

CERTIFICATE OF DEATH

Reg. Dist. No.

02786

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVIERA BEACH</u>		c. LENGTH OF STAY IN 1b <u>3 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BAY DRIVE</u>		1d. STREET ADDRESS <u>BAY DRIVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>A.</u> Last <u>NORRIS</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 18, 1871</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANDY MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANDY FACTORY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EVA G. PASSAUER</u> Address <u>RIVIERA BEACH, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) <u>3 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>56</u> , to <u>MARCH 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MARCH 6</u> , 19 <u>58</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Riviera Beach, MD.</u> DATE SIGNED <u>3/7/58</u>	
PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u>		<u>RIVIERA BEACH, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 10, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u> ADDRESS <u>4001 RITCHIE HWY</u>		24a. REC'D BY REGISTRAR DATE <u>MARCH 11 1958</u>	
		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

RECEIVED

MAR 11 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

2826 CERTIFICATE OF DEATH

02787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Solley</u>		c. LENGTH OF STAY IN 1b <u>X Solley</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 Solley, Md.</u>		d. STREET ADDRESS <u>Box 36</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eunice</u> Middle <u>Olafson</u> Last <u>Olafson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-99</u>
9. AGE (In years last birthday) <u>58 yrs.</u>		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u>	
IF UNDER 24 HRS. Hours <u>5</u> Min. <u>8</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OK</u>	
11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>		12. CITIZEN OF WHAT COUNTRY? <u>OK</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Family</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Bronchopneumonia</u> DUE TO <u>433.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>auricular Fibrillation</u> DUE TO <u>multiple emboli</u> (c) <u>Arteriosclerotic Cardiac Vascular</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerotic Cardiac Vascular</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 3, 1957</u> to <u>3-8-58</u> , that I last saw the deceased alive on <u>3-8-58</u> , and that death occurred at <u>3-8-58</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry Summers</u> M.D.		ADDRESS (Street, city or town, state) <u>110 Parkway, Baltimore, Md.</u>	
PHYSICIAN'S NAME (Type) <u>H. G. Summers</u>		DATE SIGNED <u>March 12, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-13-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McElly Funeral Home</u>		ADDRESS <u>Balto.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Quinn</u>	

CERTIFICATE OF DEATH

RECEIVED
 MAR 12 1953
 BUREAU V. S.

TAMM BOND

DEPT. OF CORRECTIONS
 STATE OF NEW YORK
 ALBANY, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2827

CERTIFICATE OF DEATH

02788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 BROOKLYN PARK - A.A. Co. - MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 - 7th Ave.</u>		d. STREET ADDRESS <u>1 102 - 7th Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGIA</u> Middle <u>OWENS</u> Last <u>OWENS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 22 - 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WOLFORD</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>	
17. INFORMANT <u>CLARENCE OWENS - 102 - 7th Ave</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 CONGESTIVE HEART FAILURE</u> DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u>10 YEARS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER, 19 56</u> , to <u>MAR 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAR 1</u> , 19 <u>58</u> , and that death occurred at <u>P.A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Benjamin Berdum</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>5010 A Ritchie Hwy Baltimore 25 MD</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLEN HAVEN Cem</u>	22d. LOCATION (City, town, or county) (State) <u>RITCHIE Hgh. BALTO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THOMAS J. KENNY Inc. - 1600 Hollins St</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAR 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Paul</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2752

CERTIFICATE OF DEATH

Reg. Dist. No. 02789

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Ben Hospital</i>		e. STREET ADDRESS <i>Severna Park</i>	
3. NAME OF DECEASED (Type or print) <i>Sedonia</i> First Middle Last		4. DATE OF DEATH <i>Mar. 17</i> 19 <i>58</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>color</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 20 1891</i>
9. AGE (In years last birthday) <i>66</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Robinson</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas Butler</i>		14. MOTHER'S MAIDEN NAME <i>Lena Miles</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebro-vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-3-58</i> , 19 to <i>3-17-58</i> , 19, that I last saw the deceased alive on <i>3-17-58</i> , 19, and that death occurred at <i>8:50</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. T. Allen</i>		DATE SIGNED <i>3-18-58</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		ADDRESS (Street, city or town, state) <i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Mar. 20/58</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Townes</i>		22d. LOCATION (City, town, or county) (State) <i>Severna Park Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 21 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

BUREAU V. S.

MAR 21 1953

RECEIVED

2828

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY New York			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital				d. STREET ADDRESS 201 Oak Street Box 2, Linden Apts			
3. NAME OF DECEASED (Type or print) First DIANE Middle IRMA Last PARADISO				4. DATE OF DEATH Month MARCH Day 4 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Jan 1958		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 1 Days 4	IF UNDER 24 HRS. Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NA		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Paradiso				14. MOTHER'S MAIDEN NAME Irma Jaszczurski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -		17. INFORMANT (Father) Eugene Paradiso, Box 2, Linden Apts, Jessups,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure 756.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) electrolyte imbalance DUE TO (c) duodenal stenosis and duodenal band PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malrotation, midgut volvulus, duodenal band.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 Feb , 19 58 , to 4 Mar , 19 58 , that I last saw the deceased alive on 13 Mar , 19 58 , and that death occurred at 3:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Samuel D. Gaby				M.D. U. S. ARMY HOSPITAL FT MEADE, MD 4 Mar 58			
PHYSICIAN'S NAME (Type) SAMUEL D. GABY, MD				U. S. ARMY HOSPITAL FT MEADE, MD			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF 4/6/58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Woberton Funeral Home, Inc				24a. REC'D BY REGISTRAR DATE 4 Mar 58		24b. REGISTRAR'S SIGNATURE CLAUDE D LAUSIER, CWO	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Island: 100

010001 1 000000

Estadística 1999

etiam etiam

070472 000000

(1000)

907

BUREAU V. S.

MAR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 Film G227 3-28-58 et

Item 1 Film G227 3-28-58 et

2753

CERTIFICATE OF DEATH

Reg. Dist. No.

02790

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA General</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Leon</u> First <u>Parker JR</u> Middle <u>Parker JR</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/2/1957</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lothian Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Leon Parker</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Downs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-20-58</u> , 1958, to <u>3-20-58</u> , 1958, that I last saw the deceased alive on <u>3-20-58</u> , 1958, and that death occurred at <u>6:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6544 W 37th Ave, Annapolis, Md.</u> DATE SIGNED <u>3/20/58</u>			
ACTUAL SIGNATURE <u>James R. Martin</u> M.D.			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Adams</u>		22d. LOCATION (City, town, or county) (State) <u>Lothian Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Hardisty</u> ADDRESS <u>Salisbury Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. E. Smith</u>			

MAR 26 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.



2823 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04163
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>B. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brewery Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brewery Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brewery Maryland</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First <u>Powell</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>7 Cook</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Alexander Powell Brewery Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>coronary artery occlusion</u> (c), stating the underlying cause lost. DUE TO <u>coronary arteriosclerosis.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Ernie H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-5-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>
22d. LOCATION (City, town, or county) <u>Brewery Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keasett</u>		ADDRESS <u>108 Wash St. Anna. Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Al C. Smith</u>	
DATE <u>APR 1 0 '58</u>			

MEDICAL CERTIFICATION

STATE
HOSPITAL



RECEIVED
BIRMINGHAM
APR 11 1938

STATE OF ALABAMA
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BURKAU V. S.

APR 11 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03068

2754

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL				e. STREET ADDRESS Davidsonville Rd			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First HAZEL Middle G Last PURDHAM				4. DATE OF DEATH Month MARCH Day 30 Year 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 21, 1913		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Severn, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry C. Knight				14. MOTHER'S MAIDEN NAME Mary E. Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Christopher Purdham- Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 Hrs 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X Diabetes Mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month 19	Day 19	Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Gambrills Md	(County) Md (State) Md
21. I certify that I attended the deceased from Jan 1955 , to Mar 30, 1958 , that I last saw the deceased alive on Mar 27, 1958 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward G Skeritt				ADDRESS (Street, city or town, state) Gambrills Md		DATE SIGNED 3-31-58	
PHYSICIAN'S NAME (Type) Edward Skeritt MD				Gambrills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-2-1958		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE APR 3 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			

CERTIFICATE OF DEATH

Form 100-10

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

PLACE OF BIRTH: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

DATE OF MARRIAGE: [illegible]

NAME OF SPOUSE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

AGE: [illegible]

SEX: [illegible]

CAUSE OF DEATH: [illegible]

BUREAU V. 2

APR 7 1953

RECEIVED

1
21.1
*
M
63

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2755 CERTIFICATE OF DEATH

Reg. Dist. No.

02791

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>F.A. GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>M.</u> Last <u>PURDIE</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-19-1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>14</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>77</u> Days <u>14</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PROFESSOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COLLEGE (U.S.U.A)</u>	
11. BIRTHPLACE (State or foreign country) <u>Mexico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>Samuel Alexander Purdie</u>		14. MOTHER'S MAIDEN NAME <u>G. Hoover</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MAYME B. PURDIE</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>undetermined</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 3/13</u> , 19 <u>57</u> , to <u>3/14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/13</u> , 19 <u>58</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. <u>68 Franklin St</u>		DATE SIGNED <u>3/13/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVAL ACADEMY</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 19 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 19 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2756

CERTIFICATE OF DEATH

02792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. C. General Hosp.</u>		e. STREET ADDRESS <u>Camp Lett Bld.</u>	
3. NAME OF DECEASED (Type or print) <u>Henrietta Randall</u>		4. DATE OF DEATH Month <u>3</u> Day <u>14</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-4-1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Butler</u>		14. MOTHER'S MAIDEN NAME <u>Lubenia Watkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>770</u>	
17. INFORMANT <u>William Brown - Balto. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>4-4-57</u> to <u>3-15-58</u> , that I last saw the deceased alive on <u>3-15-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. T. Allen</u>		DATE SIGNED <u>3-17-58</u>	
PHYSICIAN'S NAME (Type) <u>W. T. Allen</u>		ADDRESS (Street, city or town, state) <u>6100 Edgewood Dr. Baltimore, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-19-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Chapel</u>		22d. LOCATION (City, town, or county) <u>Edgewater, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		ADDRESS _____	
24a. REC'D BY REGISTRAR <u>W. T. Allen</u>		24b. REGISTRAR'S SIGNATURE <u>W. T. Allen</u>	
DATE <u>MAR 18 '58</u>			

CERTIFICATE OF DEATH

PLACE IN DEATH		MAY 19 1939	
NAME OF DECEASED		MAY 19 1939	
AGE		MAY 19 1939	
SEX		MAY 19 1939	
RACE		MAY 19 1939	
BIRTH DATE		MAY 19 1939	
BIRTH PLACE		MAY 19 1939	
MARRIAGE DATE		MAY 19 1939	
MARRIAGE PLACE		MAY 19 1939	
OCCUPATION		MAY 19 1939	
CAUSE OF DEATH		MAY 19 1939	
MANNER OF DEATH		MAY 19 1939	
PLACE OF DEATH		MAY 19 1939	
DATE OF DEATH		MAY 19 1939	
SIGNATURE		MAY 19 1939	
WITNESS		MAY 19 1939	
DOCTOR		MAY 19 1939	
CITY		MAY 19 1939	
COUNTY		MAY 19 1939	
STATE		MAY 19 1939	
FEDERAL BUREAU OF INVESTIGATION		MAY 19 1939	
U.S. DEPARTMENT OF JUSTICE		MAY 19 1939	
WASHINGTON, D.C.		MAY 19 1939	

BUREAU V. S.

MAR 19 1939

RECEIVED

2757

CERTIFICATE OF DEATH

02793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EMMA Middle MADELINE Last REARDON				4. DATE OF DEATH Month March Day 29 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 9, 1885	
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min.		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cleaning (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Westinghouse			
13. FATHER'S NAME John Ryan				14. MOTHER'S MAIDEN NAME Bridgett Gibney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 169-01-4095			
17. INFORMANT Mrs. Marie A. Thomas				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 592x DUE TO Chr. Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Nephritis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 days yes.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral Thrombosis & St. Hemiplegia. Anomalous Fibulation							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from 3/26 , 19 58 , to 3/29 , 19 58 , that I last saw the deceased alive on 3/28 , 19 58 , and that death occurred at 10:05 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 31 Santa Catalina Ave. Annapolis, Md. DATE SIGNED 3/29/58 ACTUAL SIGNATURE Maurice F. Krawans M.D. PHYSICIAN'S NAME (Type) MAURICE F. KRAWANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 2, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cem.		22d. LOCATION (City, town, or county) (State) North Versailles Township, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Funeral Home				ADDRESS Anne Arundel		24a. REC'D BY REGISTRAR APR 1 '58	
24b. REGISTRAR'S SIGNATURE Alb. Leach							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 1 1953

RECEIVED

2758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>16 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>A.</u> Last <u>REUSING, JR.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1910</u>		9. AGE (In years last birthday) <u>47</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Collison Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>Elvaton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>John A Reusing, Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>Alverta Pumphrey</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>unknown</u>				17. INFORMANT <u>Mrs. Charles Wilson</u> Address <u>Elvaton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> DUE TO <u>Carcinoma of bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>approx 10 weeks</u> (c) <u>approx 10 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>7:00</u> p. m. <u>7:00</u> 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 18, 1958</u> , to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>March 5, 1958</u> , and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Oldham M.D.</u>				ADDRESS (Street, city or town, state) <u>98 Cathedral St Annapolis Md</u>			
PHYSICIAN'S NAME (Type) <u>W. R. Oldham</u>				DATE SIGNED <u>March 7 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>AR 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>AR 7 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2759

CERTIFICATE OF DEATH

Reg. Dist. No.

02795

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills			
				d. STREET ADDRESS 1			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (Newborn - unnamed)				4. DATE OF DEATH Month March Day 15 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1958	
				9. AGE (In years last birthday) yrs. 10		IF UNDER 1 YEAR Months 10 Days 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME James Ridgley				14. MOTHER'S MAIDEN NAME Alice Queen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mother	
				Address Gambrills, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atalectysis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity							
INTERVAL BETWEEN ONSET AND DEATH 10 hrs.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Chesapeake		(County) (State)	
21. I certify that I attended the deceased from Mar. 14, 1958 , to Mar. 15, 1958 , that I last saw the deceased alive on Mar. 15, 1958 , and that death occurred at 9:30A M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert A. Riley, Jr.				ADDRESS (Street, city or town, state) 69 Franklin St., Annapolis, Md.			
PHYSICIAN'S NAME (Type) Dr. Robert A. Riley, Jr.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Mar. 17 1958		22c. NAME OF CEMETERY OR CREMATORY St. Sabot		22d. LOCATION (City, town, or county) (State) Chesapeake	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Johnson				ADDRESS Annapolis		24a. REC'D BY REGISTRAR DATE MAR 19 58	
				24b. REGISTRAR'S SIGNATURE W. J. ...			

2063330XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

RECEIVED
MAR 19 1959
BUREAU V. S.

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. MEDICAL HISTORY [Faint text]		10. HISTORY OF PRESENT ILLNESS [Faint text]		11. HISTORY OF PREVIOUS ILLNESSES [Faint text]		12. HISTORY OF SURGERY [Faint text]	
13. HISTORY OF DRUGS [Faint text]		14. HISTORY OF ALCOHOL [Faint text]		15. HISTORY OF TOBACCO [Faint text]		16. HISTORY OF OTHER HABITS [Faint text]	
17. HISTORY OF TRAUMA [Faint text]		18. HISTORY OF INFECTION [Faint text]		19. HISTORY OF MENTAL ILLNESS [Faint text]		20. HISTORY OF OTHER CONDITIONS [Faint text]	
21. HISTORY OF ALLERGIC REACTIONS [Faint text]		22. HISTORY OF CHRONIC DISEASES [Faint text]		23. HISTORY OF ACUTE DISEASES [Faint text]		24. HISTORY OF OTHER CONDITIONS [Faint text]	
25. HISTORY OF OTHER CONDITIONS [Faint text]		26. HISTORY OF OTHER CONDITIONS [Faint text]		27. HISTORY OF OTHER CONDITIONS [Faint text]		28. HISTORY OF OTHER CONDITIONS [Faint text]	
29. HISTORY OF OTHER CONDITIONS [Faint text]		30. HISTORY OF OTHER CONDITIONS [Faint text]		31. HISTORY OF OTHER CONDITIONS [Faint text]		32. HISTORY OF OTHER CONDITIONS [Faint text]	
33. HISTORY OF OTHER CONDITIONS [Faint text]		34. HISTORY OF OTHER CONDITIONS [Faint text]		35. HISTORY OF OTHER CONDITIONS [Faint text]		36. HISTORY OF OTHER CONDITIONS [Faint text]	
37. HISTORY OF OTHER CONDITIONS [Faint text]		38. HISTORY OF OTHER CONDITIONS [Faint text]		39. HISTORY OF OTHER CONDITIONS [Faint text]		40. HISTORY OF OTHER CONDITIONS [Faint text]	
41. HISTORY OF OTHER CONDITIONS [Faint text]		42. HISTORY OF OTHER CONDITIONS [Faint text]		43. HISTORY OF OTHER CONDITIONS [Faint text]		44. HISTORY OF OTHER CONDITIONS [Faint text]	
45. HISTORY OF OTHER CONDITIONS [Faint text]		46. HISTORY OF OTHER CONDITIONS [Faint text]		47. HISTORY OF OTHER CONDITIONS [Faint text]		48. HISTORY OF OTHER CONDITIONS [Faint text]	
49. HISTORY OF OTHER CONDITIONS [Faint text]		50. HISTORY OF OTHER CONDITIONS [Faint text]		51. HISTORY OF OTHER CONDITIONS [Faint text]		52. HISTORY OF OTHER CONDITIONS [Faint text]	
53. HISTORY OF OTHER CONDITIONS [Faint text]		54. HISTORY OF OTHER CONDITIONS [Faint text]		55. HISTORY OF OTHER CONDITIONS [Faint text]		56. HISTORY OF OTHER CONDITIONS [Faint text]	
57. HISTORY OF OTHER CONDITIONS [Faint text]		58. HISTORY OF OTHER CONDITIONS [Faint text]		59. HISTORY OF OTHER CONDITIONS [Faint text]		60. HISTORY OF OTHER CONDITIONS [Faint text]	
61. HISTORY OF OTHER CONDITIONS [Faint text]		62. HISTORY OF OTHER CONDITIONS [Faint text]		63. HISTORY OF OTHER CONDITIONS [Faint text]		64. HISTORY OF OTHER CONDITIONS [Faint text]	
65. HISTORY OF OTHER CONDITIONS [Faint text]		66. HISTORY OF OTHER CONDITIONS [Faint text]		67. HISTORY OF OTHER CONDITIONS [Faint text]		68. HISTORY OF OTHER CONDITIONS [Faint text]	
69. HISTORY OF OTHER CONDITIONS [Faint text]		70. HISTORY OF OTHER CONDITIONS [Faint text]		71. HISTORY OF OTHER CONDITIONS [Faint text]		72. HISTORY OF OTHER CONDITIONS [Faint text]	
73. HISTORY OF OTHER CONDITIONS [Faint text]		74. HISTORY OF OTHER CONDITIONS [Faint text]		75. HISTORY OF OTHER CONDITIONS [Faint text]		76. HISTORY OF OTHER CONDITIONS [Faint text]	
77. HISTORY OF OTHER CONDITIONS [Faint text]		78. HISTORY OF OTHER CONDITIONS [Faint text]		79. HISTORY OF OTHER CONDITIONS [Faint text]		80. HISTORY OF OTHER CONDITIONS [Faint text]	
81. HISTORY OF OTHER CONDITIONS [Faint text]		82. HISTORY OF OTHER CONDITIONS [Faint text]		83. HISTORY OF OTHER CONDITIONS [Faint text]		84. HISTORY OF OTHER CONDITIONS [Faint text]	
85. HISTORY OF OTHER CONDITIONS [Faint text]		86. HISTORY OF OTHER CONDITIONS [Faint text]		87. HISTORY OF OTHER CONDITIONS [Faint text]		88. HISTORY OF OTHER CONDITIONS [Faint text]	
89. HISTORY OF OTHER CONDITIONS [Faint text]		90. HISTORY OF OTHER CONDITIONS [Faint text]		91. HISTORY OF OTHER CONDITIONS [Faint text]		92. HISTORY OF OTHER CONDITIONS [Faint text]	
93. HISTORY OF OTHER CONDITIONS [Faint text]		94. HISTORY OF OTHER CONDITIONS [Faint text]		95. HISTORY OF OTHER CONDITIONS [Faint text]		96. HISTORY OF OTHER CONDITIONS [Faint text]	
97. HISTORY OF OTHER CONDITIONS [Faint text]		98. HISTORY OF OTHER CONDITIONS [Faint text]		99. HISTORY OF OTHER CONDITIONS [Faint text]		100. HISTORY OF OTHER CONDITIONS [Faint text]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2760 CERTIFICATE OF DEATH

Reg. Dist. No.

02796

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S.N.H. ANNAPOLIS, MD.		d. STREET ADDRESS #4 OKLAHOMA TERRACE	
3. NAME OF DECEASED (Type or print) First Ettie Middle Catherine Last ROBBINS		4. DATE OF DEATH Month March Day 12 Year 1958	
5. SEX Female	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 Jan 1910
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		11b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11c. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Dennis Orville LOCKMAN		14. MOTHER'S MAIDEN NAME Catherine Margaurette WILLIAMS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT U.S.N.H. ANNAPOLIS, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Artery Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Metastases, mediastinum DUE TO (c) Carcinoma, urinary bladder		INTERVAL BETWEEN ONSET AND DEATH 14 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11 Mar , 19 58 , to 12 Mar , 19 58 , that I last saw the deceased alive on 12 Mar , 19 58 , and that death occurred at 3:35P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter W. Weber		DATE SIGNED U.S.N.Hosp. Annapolis, Md. 3-13-58	
PHYSICIAN'S NAME (Type) CAPT. W.M. WEBER MC USN		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-18-58	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Saylor Sins		ADDRESS Annapolis Md.	
24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE W. J. Search	

MAR 17 1958

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Form 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



20 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 2, 8, 9, 10b, 11, 12, 13, 14 Film G226 3-26-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville Frederick 10112			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 16 Carver Apts. Crownsville State Hospital			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle ROSS Last ROSS				4. DATE OF DEATH Month March Day 2 Year 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 28, 1902	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Ross				14. MOTHER'S MAIDEN NAME Nannie (maiden name unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Russell S. Fisher, M.D.		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 3/3/58					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 3/14/58	22c. NAME OF CEMETERY OR CREMATORY Crownsville		22d. LOCATION (City, town, or county) Crownsville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles W. M. Fisher		ADDRESS Crownsville State Hosp		24a. REC'D BY REGISTRAR DATE MAR 18 '58	24b. REGISTRAR'S SIGNATURE Charles W. M. Fisher		

MEDICAL CERTIFICATION

2

2



RECEIVED

MAR 18 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 11, 14, 22a, b, c & d Film G-227 4/9/58.cac
Also: items 8 & 9. **CERTIFICATE OF DEATH**

2831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - LAKE SHORE</u>		c. LENGTH OF STAY IN 1b <u>11 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAKE SHORE DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>RUTH LORETTA</u> First Middle Last		4. DATE OF DEATH <u>MARCH 31</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 1893</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Turner</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u> <u>2 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>57</u> , to <u>MARCH 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>58</u> , and that death occurred at <u>10:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Riviera Beach, Maryland</u> DATE SIGNED <u>3/31/58</u> ACTUAL SIGNATURE <u>J. Brady Smith</u> M.D. <u>Riviera Beach, Md.</u> PHYSICIAN'S NAME (Type) <u>J. BRADY SMITH</u> <u>RIVIERA BEACH, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McLully Funeral Home</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02798

2832

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 19ys3mos,27da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2		d. STREET ADDRESS 405 N. Potomac Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sallie Middle Saunders Last Saunders		4. DATE OF DEATH Month 3 Day 13 Year 19 58	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 13 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Phoenix		14. MOTHER'S MAIDEN NAME Mary E. Gillis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypostatic Pneumonia DUE TO (c) Arteriosclerotic Cardiovascular Renal Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, Dehydration, Decubitus Ulcers, Right Hemiplegia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Hour a. m. ----- p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from July , 19 56 , to March 13 , 19 58 , that I last saw the deceased alive on March 13 , 19 58 , and that death occurred at 10:26pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/14/58			
ACTUAL SIGNATURE [Signature]		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 3.17.58	22c. NAME OF CEMETERY OR CREMATORY St. of Md. Neel School	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W M Reese		24a. REC'D BY REGISTRAR 108 W Wash St	
24b. REGISTRAR'S SIGNATURE [Signature]		DATE MAR 18 '58	

CERTIFICATE OF DEATH

BURIAU Y. S.

MAR 19 1938

RECEIVED

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

2761

CERTIFICATE OF DEATH

02799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA CO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>3 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOA Anne Arundel Gen. Hospital</u>		e. STREET ADDRESS <u>Rte 4, Bx132, CAPE ST. CLAIRE</u>	
3. NAME OF DECEASED (Type or print) First <u>MARIE</u> Middle <u>SCHMICK</u> Last <u>SCHMICK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/1870?</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AUSTRIA</u>	
13. FATHER'S NAME <u>John Schmick</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Rush</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>48 HRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>58</u> , to <u>3/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/18</u> , 19 <u>58</u> , and that death occurred at <u>4:50 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Peeler</u> M.D.		ADDRESS (Street, city or town, state) <u>68 Franklin St. Annapolis, Md.</u>	
DATE SIGNED <u>3/20/58</u>			
PHYSICIAN'S NAME (Type) <u>RICHARD A. PEELER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Potomac Maryland Glen Haven Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin G. Fink</u> ADDRESS <u>Glen Haven Md</u>		24a. REC'D BY REGISTRAR <u>MAR 24 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

CERTIFICATE OF DEATH

FILE NO.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
MARITAL STATUS		EDUCATION		OCCUPATION		RELIGION		MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE OF DEATH		UNDERLYING CAUSE OF DEATH		MORBIDITY	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT		STATE OF INTERMENT	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN		SIGNATURE OF CLERK		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF PROSECUTOR		SIGNATURE OF DEFENSE	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2833

CERTIFICATE OF DEATH

Reg. Dist. No.

02800

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BROOKLYN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 50 BROOKLYN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5111 KRAMMIE AVE		d. STREET ADDRESS 5111 KRAMMIE AVE.	
3. NAME OF DECEASED (Type or print) First AUGUST Middle Carl Last Schulz		4. DATE OF DEATH Month 7 Day 3 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5 - 1902
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Pa.	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME AUGUST Schulz		14. MOTHER'S MAIDEN NAME Ann Schindelhut	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT FAMILY		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 340.3 Pylonephritis DUE TO (b) Arochnoiditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 months 4 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/11/58 , 19 58 , to 3/10 , 19 58 , that I last saw the deceased alive on 3/10 , 19 58 , and that death occurred at 6:35 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4700 Pennington Ave. DATE SIGNED 3/11/58 ACTUAL SIGNATURE Sidney R. Gehlert M.D. PHYSICIAN'S NAME (Type) Sidney R. Gehlert M.D. 4700 Pennington Avenue Balto. 26, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-15	
22c. NAME OF CEMETERY OR CREMATORY Southside Cem.		22d. LOCATION (City, town, or county) (State) P. Hsburg. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		ADDRESS 138 E. Fort Ave.	
24a. REC'D BY REGISTRAR DATE MAR 12 '58		24b. REGISTRAR'S SIGNATURE Reed	

CERTIFICATE OF DEATH

1953

REGISTRATION

DATE OF DEATH

CITY

COUNTY

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

MAR 12 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04167

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shadyside Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Shadyside Md</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Scott</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-4-1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owning & farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Scott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Cross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wilson Scott</u> Address <u>Shadyside Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>uremia, ?</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-1-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4-3-1958</u>	<u>St. Matthews</u>	<u>Shadyside Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>108 Wash St. Annapole</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
		DATE <u>APR 1 0 '58</u>	<u>Overman</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

APR 11 1959

BUREAU V. 8

FOR STATE
DEPT. OF JUSTICE

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2762

CERTIFICATE OF DEATH

Reg. Dist. No.

02801

1. PLACE OF DEATH o. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 10 Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH Annapolis, Md.		d. STREET ADDRESS 123 Severn Ave.	
3. NAME OF DECEASED (Type or print) First Katharine Sophie Middle SEEBOHM Last 4. DATE OF DEATH Month Mar. Day 13 Year 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-72
9. AGE (In years last birthday) yrs. 85		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Homemaker	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Henry C. MATZEN		14. MOTHER'S MAIDEN NAME Katherine M. Giles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	
17. INFORMANT USNH.		Address ANNAPOLIS, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis right coronary artery 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-10 , 19 58 , to 3-13 , 19 58 , that I last saw the deceased alive on 3-12 , 19 58 , and that death occurred at 12:40A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter W. Weber		ADDRESS (Street, city or town, state) U.S.N. Hosp. Annapolis, Md. DATE SIGNED 3-13-58	
PHYSICIAN'S NAME (Type) CAPT W. M. WEBER MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-16-58	
22c. NAME OF CEMETERY OR CREMATORY St Annes		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		ADDRESS Annapolis Md.	
24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE Reed	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2835 CERTIFICATE OF DEATH

Reg. Dist. No. 02802

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA</u>		c. LENGTH OF STAY IN 1b <u>5 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X PASADENA</u>	
		d. STREET ADDRESS <u>BROOKFIELD RD. Rt 8 Box 67</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES</u> First <u>—</u> Middle <u>SHEMENSKI</u> Last		4. DATE OF DEATH <u>MARCH 25</u> Month <u>1958</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 11 1884</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOSEPH A. KWASNY</u>		14. MOTHER'S MAIDEN NAME <u>ROSALIE SUTER (SETNEK)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HELEN SHEMENSKI</u> Address <u>PASADENA BROOKFIELD RD. MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>NEPHRITIS, VASCULAR</u> DUE TO (c) <u>HODGKINS DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 DAYS</u> <u>3 MO.</u> <u>12 MO.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 6</u> , 19 <u>58</u> , to <u>MAR. 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>MAR 23</u> , 19 <u>58</u> , and that death occurred at <u>10:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mountain Rd. Pasadena Md.</u> DATE SIGNED ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR. MOUNTAIN RD. PASADENA, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-29-58</u>		22b. DATE THEREOF <u>3-29-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCurly Funeral Homes</u> ADDRESS		24a. REC'D BY REGISTRAR <u>RESEARCH</u> 24b. REGISTRAR'S SIGNATURE <u>RESEARCH</u>	
DATE <u>MAR 28 '58</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2836

CERTIFICATE OF DEATH

Reg. Dist. No.

02803

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Edgewater, Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bruce</u> First <u>Smith</u> Middle Last		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4, 1956</u>
9. AGE (In years lost birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Smith</u>		14. MOTHER'S MAIDEN NAME <u>Helen Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Helen Smith</u>		Address <u>Edgewater Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Tracheo bronchitis</u> 500X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-3</u> , 19 <u>58</u> , to <u>3-4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-3</u> , 19 <u>58</u> , and that death occurred at <u>10:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D.		ADDRESS (Street, city or town, state) <u>62 Cathedral St Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u>		DATE SIGNED <u>3-5-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-7-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moses Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beesett</u>		ADDRESS <u>108 Wash St. Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

BUREAU V. S.

MAR 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02804

2763

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b X Crownsville P.O.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS Harold Harbor	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FLORENCE Middle R Last SMITH		4. DATE OF DEATH Month MARCH Day 11 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 18, 1898
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Danville, Virginia
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Ralph Middleton		14. MOTHER'S MAIDEN NAME Cathering Burns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mr. William G. Smith - Husband - same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 yrs INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260.1 Embolism of lung; diabetes mellitus.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 9 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/7 , 19 58 , to 3/11 , 19 58 , that I last saw the deceased alive on 3/11 , 19 58 , and that death occurred at 2 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John L. Hedeman		DATE SIGNED 3/14/58	
PHYSICIAN'S NAME (Type) John Hedeman MD		ADDRESS (Street, city or town, state) 68 Franklin St. Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 15, 58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemot.	22d. LOCATION (City, town, or county) (State) Annapolis, Md.
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		24a. REC'D BY REGISTRAR DATE MAR 17 '58	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE DeLester	

CERTIFICATE OF DEATH

Form 10-1-54

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. DATE OF BIRTH		14. PLACE OF BIRTH	
15. MARRIED		16. SINGLE	
17. WIDOW		18. DIVORCED	
19. DECEASED		20. SURVIVED	
21. DECEASED		22. SURVIVED	
23. DECEASED		24. SURVIVED	
25. DECEASED		26. SURVIVED	
27. DECEASED		28. SURVIVED	
29. DECEASED		30. SURVIVED	
31. DECEASED		32. SURVIVED	
33. DECEASED		34. SURVIVED	
35. DECEASED		36. SURVIVED	
37. DECEASED		38. SURVIVED	
39. DECEASED		40. SURVIVED	
41. DECEASED		42. SURVIVED	
43. DECEASED		44. SURVIVED	
45. DECEASED		46. SURVIVED	
47. DECEASED		48. SURVIVED	
49. DECEASED		50. SURVIVED	
51. DECEASED		52. SURVIVED	
53. DECEASED		54. SURVIVED	
55. DECEASED		56. SURVIVED	
57. DECEASED		58. SURVIVED	
59. DECEASED		60. SURVIVED	
61. DECEASED		62. SURVIVED	
63. DECEASED		64. SURVIVED	
65. DECEASED		66. SURVIVED	
67. DECEASED		68. SURVIVED	
69. DECEASED		70. SURVIVED	
71. DECEASED		72. SURVIVED	
73. DECEASED		74. SURVIVED	
75. DECEASED		76. SURVIVED	
77. DECEASED		78. SURVIVED	
79. DECEASED		80. SURVIVED	
81. DECEASED		82. SURVIVED	
83. DECEASED		84. SURVIVED	
85. DECEASED		86. SURVIVED	
87. DECEASED		88. SURVIVED	
89. DECEASED		90. SURVIVED	
91. DECEASED		92. SURVIVED	
93. DECEASED		94. SURVIVED	
95. DECEASED		96. SURVIVED	
97. DECEASED		98. SURVIVED	
99. DECEASED		100. SURVIVED	

BUREAU X. B.

MAR 17 1959

RECEIVED

2837

CERTIFICATE OF DEATH

Reg. Dist. No.

02805

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>50 Brooklyn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>225 Doris Ave.</u>		d. STREET ADDRESS <u>225 Doris Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle <u>Vera Frances</u> <u>Aimee Smith</u>		4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21, 1912</u>
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Franklin Kohlhafer</u>		14. MOTHER'S MAIDEN NAME <u>Verna Narvell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family</u>	
17. INFORMANT <u>Family</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerotic cordiell</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>53</u> , to <u>Feb.</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 18</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene Schnitzer</u>		ADDRESS (Street, city or town, state) <u>3904 S. HANOVER ST.</u> DATE SIGNED <u>3-13-58</u>	
PHYSICIAN'S NAME (Type) <u>Eugene Schnitzer, M.D.</u>		M.D. _____	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Homes</u>		ADDRESS <u>Baltimore Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Redbeach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

MODE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

TIME OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

TIME OF DEATH

AGE AT DEATH

SEX

RACE

BURKAW Y. F.

MAR 17 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02806

2764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 174 West Street				d. STREET ADDRESS 174 West Street			
3. NAME OF DECEASED (Type or print) First EVA Middle SODENSKY Last				4. DATE OF DEATH Month MARCH Day 22 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 20, 1891	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 23-34-8534			
17. INFORMANT Mr. Paul Sodensky- Son - Same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia & Chronic Congestive failure 260X DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes M. (c) Diabetic gangrene, rt. foot PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic gangrene, rt. foot INTERVAL BETWEEN ONSET AND DEATH 3 wks. many yrs. " "							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11-6-1955 to 3-22-1958 , that I last saw the deceased alive on 3-22-1958 , and that death occurred at 4:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 3-24-58							
ACTUAL SIGNATURE Frank M Shipley M.D.				PHYSICIAN'S NAME (Type) Frank Shipley MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-24-58		22c. NAME OF CEMETERY OR CREMATORY Kneseth Israel Cemetery	
22d. LOCATION (City, town, or county) Annapolis, Maryland				(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE MAR 27 '58	
24b. REGISTRAR'S SIGNATURE W. J. Leach							

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Reg. No. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

DATE OF DEATH

TIME

PLACE OF DEATH

CAUSE OF DEATH

SEX

DATE OF BIRTH

RELIGION

BUREAU V. 5

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2838

CERTIFICATE OF DEATH

Reg. Dist. No. 02807

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena RFD (Sunset Knoll)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (RFD) Sunset Knoll</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bridge Road</u>		d. STREET ADDRESS <u>Bridge Road - Rt. 5 - Box 61</u>	
3. NAME OF DECEASED (Type or print) <u>Karl</u> First <u>Steidinger</u> Middle Last		4. DATE OF DEATH <u>March</u> Month <u>26</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-17-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Sigrist</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-07-8160</u>	
17. INFORMANT <u>M. Alwin Ohler</u>		Address <u>2804 Summit Ave, Balto. #39, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Sigmoid</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to <u>March</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-24-58</u> , 19____, and that death occurred at <u>10:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>3-27-58</u>			
ACTUAL SIGNATURE <u>C. B. MacDonald</u> M.D.		DATE SIGNED <u>3-27-58</u>	
PHYSICIAN'S NAME (Type) <u>Charles R. MacDonald</u>		Glen Burnie, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Alfred Smith</u> DATE <u>MAR 31 '58</u>	
24b. REGISTRAR'S SIGNATURE			

MAR 31 1953

RECEIVED
MAR 31 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2765

CERTIFICATE OF DEATH

02808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write "RURAL and give nearest town") <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>430 SECOND ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>W.</u> Last <u>THOMAS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.A. Ret.</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ROBERT W. THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>IDA DAVIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. (If yes, give year or date of service) <u>WAT</u>	
17. INFORMANT <u>EDNA M. THOMAS</u>		Address <u># 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Occlusion</u> DUE TO <u>Atherosclerotic Cardio-Vascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disease</u> DUE TO (c) <u>Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1958</u> to <u>March 27, 1958</u> that I last saw the deceased alive on <u>March 27, 1958</u> and that death occurred at <u>2:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert L. Anderson</u> M.D.		ADDRESS (Street, city or town, state) <u>44 Southgate Ave - Annapolis, Md - 3/27/58</u>	
PHYSICIAN'S NAME (Type) <u>ALBERT L. ANDERSON M.D.</u>		DATE SIGNED <u>3/27/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-30-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

CERTIFICATE OF DEATH

Reg. No. 10

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. PLACE OF DEATH [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text]</p>		<p>14. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. S.

MAR 31 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2839

CERTIFICATE OF DEATH

02809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>		c. LENGTH OF STAY IN 1b <u>7 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S-Nursing-Home</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Tomanio</u> Last <u>Tomanio</u>				4. DATE OF DEATH Month <u>3</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-31-1904</u>	9. AGE (In years last birthday) yrs. <u>53</u>	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		10. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman + Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK Hendershot</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>136-12-6335</u>		17. INFORMANT <u>Mary V. Sann.</u>		Address <u>2601-Rd. Millersville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Dilated Hemiplegia</u> DUE TO (c) <u>Multiple Sclerosis - Generalized</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Generalized Bunsen</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>C</u>					
20c. TIME OF INJURY Month <u>1</u> Day <u>1</u> Year <u>19</u> Hour a. m. <u>1</u> p. m. <u>1</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1</u>		20f. (City or town) (County) (State) <u>1</u>	
21. I certify that I attended the deceased from <u>Dec 3-57</u> , 19 <u>57</u> , to <u>March 21-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 17-58</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Odenton Md</u> DATE SIGNED <u>3-22-58</u>							
ACTUAL SIGNATURE <u>DR. JOSEPH LIPSEY</u> PHYSICIAN'S NAME (Type) <u>ODENTON, MARYLAND</u>				24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baito, 25 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRKLEY</u> ADDRESS <u>1414 BURNIE MD</u>				24a. REC'D BY REGISTRAR <u>1</u> DATE <u>MAR 26 1958</u>		24b. REGISTRAR'S SIGNATURE <u>W. B. Smith</u>	

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAURENCE AVE.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u> d. STREET ADDRESS <u>LAURENCE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JUDY</u> Middle <u>ANN</u> Last <u>TUCKER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1953</u>
9. AGE (In years last birthday) <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NORMAN J. TUCKER</u>		14. MOTHER'S MAIDEN NAME <u>EDITH CRIDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. Lucille Hahn</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burn entire body</u> (b) <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>burn fire</u>	
20c. TIME OF INJURY Hour <u>11:04</u> o. m. <u>3-10</u> p. m. 19 <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Arkco</u> <u>Mo.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. in herett</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. in herett</u>		DATE SIGNED <u>3/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS</u> <u>Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Fay & Sons</u>		24a. REC'D BY REGISTRAR <u>Mar 26 '58</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
 MAR 26 1958
 BUREAU W. B.

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		RACE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF DEATH [Faint text]		CITY [Faint text]	
COUNTY [Faint text]		STATE [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		SIGNATURE OF EXAMINER [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF JURY [Faint text]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02811

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> 2841 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEST GATE</u>		c. LENGTH OF STAY IN 1b <u>BEST GATE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>LAURENCE AVE</u>		d. STREET ADDRESS <u>LAURENCE AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>LINDA</u> Middle <u>SUE</u> Last <u>TUCKER</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-55</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>NORMAN J. TUCKER</u>		14. MOTHER'S MAIDEN NAME <u>EDITH CRIDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>MRS. LUCILLE HALL</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>3rd degree burns entire body</u> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>House fire</u>		20c. TIME OF INJURY Month, Day, Year <u>3-20-1958</u> Hour a. m. <u>11 AM</u> p. m. <u> </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Adco rd</u>		(County) <u>Adco</u> (State) <u>Mo.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>		DATE SIGNED <u>3/20/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-24-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>Sos Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED (Print Name and Address)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF EXAMINER

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF DEPUTY SHERIFF

20. SIGNATURE OF JAILER

21. SIGNATURE OF WARDEN

22. SIGNATURE OF CHIEF OF POLICE

23. SIGNATURE OF DEPUTY CHIEF OF POLICE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DEPUTY SHERIFF

26. SIGNATURE OF JAILER

27. SIGNATURE OF WARDEN

28. SIGNATURE OF CHIEF OF POLICE

29. SIGNATURE OF DEPUTY CHIEF OF POLICE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF JAILER

33. SIGNATURE OF WARDEN

34. SIGNATURE OF CHIEF OF POLICE

35. SIGNATURE OF DEPUTY CHIEF OF POLICE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF DEPUTY SHERIFF

38. SIGNATURE OF JAILER

39. SIGNATURE OF WARDEN

40. SIGNATURE OF CHIEF OF POLICE

41. SIGNATURE OF DEPUTY CHIEF OF POLICE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF DEPUTY SHERIFF

44. SIGNATURE OF JAILER

45. SIGNATURE OF WARDEN

BUREAU Y. B.

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2842

CERTIFICATE OF DEATH

Reg. Dist. No.

03070

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md.		c. LENGTH OF STAY IN 1b 2ys, 11mos, 26d	
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital, Md.		d. STREET ADDRESS 927 Harford Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Marie Middle Richards Last Tynes		4. DATE OF DEATH Month 3 Day 31 Year 1958	
5. SEX Fem.	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1901
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alexander Richards		14. MOTHER'S MAIDEN NAME Julia Anna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 260x DUE TO Decubital Ulcers Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus and Arteriosclerosis DUE TO (c) ----- PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Brain Syndrome associated with Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- 19 p. m. -----		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from June , 19 55 , to March 31 , 19 58 , that I last saw the deceased alive on March 31 , 19 58 , and that death occurred at 3:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/31/58 ACTUAL SIGNATURE Hildegard Heard Reissmann M.D. PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4/6/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Ann Arundel County Md	
23. FUNERAL DIRECTOR'S SIGNATURE William C. March		ADDRESS 928 E North Ave	
24a. REC'D BY REGISTRAR DATE APR 7 '58		24b. REGISTRAR'S SIGNATURE W. J. March	

BUREAU V. 8

APR 8 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2843

CERTIFICATE OF DEATH

Reg. Dist. No.

02812

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena Md.</u>		d. STREET ADDRESS <u>RED - 2 Box 280 B.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S Nursing Home.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ruth J. UODUSEK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-6-1908</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Harvey B. Kershaw</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Hubbard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Ora E. Welsh. LPN.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> DUE TO <u>Cerebral Infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>1 Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension and Arterio Sclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 12-58</u> to <u>March 31-58</u> , that I last saw the deceased alive on <u>March 28-58</u> , and that death occurred at <u>1:30 p.m.</u> from the causes and on the date stated above.		DATE SIGNED <u>3-31-58</u>	
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city or town, state) <u>Clinton Md</u>	
PHYSICIAN'S NAME (Type) <u>DR. JOSEPH LIPSKEY</u>		DATE SIGNED <u>3-31-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 4/3/58</u>		22b. DATE THEREOF <u>4/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Steuwacke</u>		ADDRESS <u>108 W. York Rd.</u>	
24a. REC'D BY REGISTRAR <u>APR 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Welsh</u>	

BUREAU V. S.

APR 2 1958

RECEIVED

08/02/2014 14:29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2844

CERTIFICATE OF DEATH

Reg. Dist. No.

02813

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville, Md. c. LENGTH OF STAY IN 1b 1yr, 9mos, 2das d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 704 Westover Circle e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Frances Waller		4. DATE OF DEATH Month Day Year 3 22 19 58	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-12-1892
9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11b. KIND OF BUSINESS OR INDUSTRY CANNING	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 221-09-1205	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia due to Decubitus Ulcers 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Heart Disease DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/19 , 19 56 , to March 22 , 19 58 , that I last saw the deceased alive on March 22 , 19 58 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 3/24/58			
ACTUAL SIGNATURE Hildegard Heard Reissmann		M. D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Hildegard Heard Reissmann, M. D.		Crownsville State Hospital, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/31/58	
22c. NAME OF CEMETERY OR CREMATORY GREEN ACRE MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) Salisbury Md	
23. FUNERAL DIRECTOR'S SIGNATURE L. E. Stewart		ADDRESS Funeral Home, Salisbury, Md	
24a. REC'D BY REGISTRAR APR 2 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

UNRECORDED

BUREAU V. 3

APR 2 1939

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

2845

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena RFD		c. LENGTH OF STAY IN 1b 3 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 135 - Rt. #1 Ventnor Rd.				d. STREET ADDRESS Ventnor Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE E. WALSTRUM				4. DATE OF DEATH Month Day Year March 26, 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28 '82		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME (unknown) Strong				14. MOTHER'S MAIDEN NAME (unknown) Gilbert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none		17. INFORMANT Address Mrs. Ethel E. Schuman, Same As #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic Cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2-3 weeks months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 4, 1958, to March 27, 1958, that I last saw the deceased alive on March 26, 1958, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED R. M. McLaughlin M.D. Pasadena, Md. 2/27/58 PHYSICIAN'S NAME (Type) R. M. McLaughlin, Wt. Road, Pasadena RFD, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 29/58		22c. NAME OF CEMETERY OR CREMATORY Wesleyan Chapel Cem		22d. LOCATION (City, town, or county) (State) Harford Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE R. B. Singleton				ADDRESS Glen Burnie, Md.		24a. REG'D BY REGISTRAR MAR 31 '58 DATE	
				24b. REGISTRAR'S SIGNATURE O. J. Redick			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF NEW YORK

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

BUREAU V. S.

MAR 31 1933

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>48 Madison Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>H</u> Last <u>WAYSON</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>8</u> Year <u>19 58</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 16, 1910</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mech. Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto garage</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Albert L. Wayson</u>				14. MOTHER'S MAIDEN NAME <u>Annie May Garrick</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-05-1020</u>		17. INFORMANT <u>Thomas G. Wayson- Brother- Annapolis, Md.</u> Address <u>Spa View Ave.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u>Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>						
20c. TIME OF INJURY Hour <u>3:05</u> p.m. Month <u>March</u> Day <u>8</u> Year <u>1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Natural Causes</u>		20f. (City or town) (County) (State) <u>Annapolis, Anne Arundel Md.</u>		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED <u>March 8, 1958</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 11, 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 11 '58</u> DATE		24b. REGISTRAR'S SIGNATURE <u> </u>		

MAR 11 1958

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 Film G 227 4/3/58 OG

02816

2846 CERTIFICATE OF DEATH

Items 8,9 Film G227 4-1-58 et

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>MD</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u>		COUNTY <u>3 Vol-4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cleburne</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>1739 Jefferson ST</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Conv. Home</u>							
3. NAME OF DECEASED (First) (Middle) (Last) <u>CORA WHITE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 21 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>2-12-1909</u>	9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CHAS. HAMMOND</u>				14. MOTHER'S MAIDEN NAME <u>MOLLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Ella Collins 413 H. W. H. Co.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebro-vascular accident</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis general</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-12</u> , 19 <u>58</u> , to <u>3-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-18</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city, town, state) <u>102 Bx A Bldg. N.E. Cleburne, Md.</u>		DATE SIGNED <u>3-21-1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-23-58</u>		NAME OF CEMETERY OR CREMATORY <u>MT. CALVARY</u>		LOCATION (City, town, or county) (State) <u>A.A. County MD</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Locks' Funeral Home, 1304 n. Central Ave. Balto</u>	
DATE <u>MAR 26 '58</u>							

1

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2847

CERTIFICATE OF DEATH

Reg. Dist. No.

02817

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cc. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>Box 162 # Furnace Dr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address or institution) <u>Box 162 Furnace Dr.</u>		d. STREET ADDRESS <u>Glen Burnie Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>WILHELMIE</u> Middle <u>K.</u> Last <u>WIDMARK</u>		4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 30 1895</u>
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FERDINAND BUDDENBOHN</u>		14. MOTHER'S MAIDEN NAME <u>Anne Speer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>FAMILY</u>	
17. INFORMANT <u>above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Dissecting Aneurysm</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>1958</u> to <u>March 12, 1958</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>58</u> , and that death occurred at <u>9 A</u> .M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bryant H. Jones</u> M.D. <u>104 Crain Hwy S Glen Burnie Md</u>		DATE SIGNED <u>3/12/58</u>	
PHYSICIAN'S NAME (Type) <u>BRYANT H. JONES MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McClully Funeral Homes - Md</u>		ADDRESS <u>Baltimore</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 17 1958</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02818

2767

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>	
d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENDRIKA</u> Middle <u>WILSON</u> Last <u></u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>3</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 9, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Holland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Frederick Greentree- Son-</u>		Address <u>Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uraemia</u> <u>592x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Nephritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>late yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardio Vascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/28</u> , 19 <u>58</u> , to <u>3/3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/2</u> , 19 <u>58</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Ave. Annapolis, Md.</u> DATE SIGNED <u>Maurice Klawans</u>			
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Maurice Klawans M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-5-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Millersville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 7 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>			

CERTIFICATE OF DEATH

BUREAU V. 3

MAR 7 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G226 3-19-58 et

2769

CERTIFICATE OF DEATH

02819

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croftsville Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hospital</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Richard</u> <u>Wilson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-23-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>Martha ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-32-6658</u>	
17. INFORMANT <u>Christine Brook</u>		Address <u>1803 38A St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal Hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured peptic ulcer</u> DUE TO (c) <u>Hunt 10 days</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-25-58</u> , 19 <u>58</u> , to <u>3-3-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-3-58</u> , 19 <u>58</u> , and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. T. Allen</u>		ADDRESS (Street, city or town, state) <u>62 Colchester</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>3-3-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-8-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cheslerfield Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Rasett</u>		ADDRESS <u>#108 Wash. St. Annapolis</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

RECEIVED

1958 9 18

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2768

CERTIFICATE OF DEATH

Reg. Dist. No. 02820

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u> <u>ANNE ARUNDEL General</u>		d. STREET ADDRESS <u>51 College Crk. Terrace</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Herbert</u> Last <u>Woods</u>		4. DATE OF DEATH Month <u>MAR</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1894</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumbers Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANNAPOLIS - Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS - Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN BARNETT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-5173</u>	
17. INFORMANT <u>Mary Bashears</u> Address <u>147 Obery Court</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia, circulatory failure</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>peptic ulcer, hypertrophy of prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>493X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-11</u> , 19 <u>54</u> , to <u>3-6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-6</u> , 19 <u>58</u> , and that death occurred at <u>1 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D. <u>45 Franklin St. Annapolis</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3-8-58</u>	
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-10-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks III</u> ADDRESS <u>ANNAPOLIS - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

BUREAU V. S.

MAR 10 1969

RECEIVED